PERMISSION TO TAKE MEDICATION AT SCHOOL

(complete one form per medication)

Date: _____

Student Name: _____

School: _____

Grade/teacher/homeroom: _____

This student has juvenile idiopathic arthritis and needs to take the following medications during school hours:

Name of medication: _____

_____

Purpose of medication: _____

_____

How it is supplied (pill, liquid, eyedrop):_____

_____

Special instructions: _____

_____

_____ Take during a meal

_____ Take _____minutes before a meal

_____ The student will need to take this medication daily

_____ The student will take this medication only until_____(date)

Physician's name: _____

Physician's signature: _____

Office phone: _____

Office address: _____

Contact person (*if other than physician*):

Name_____

Phone _____

Parent's signature to release information to school:

Parent Name: _____

Signature_____ Date _____