Defiance DD
County Board of Developmental Disabilities
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Current Medication/ Treatment

If medication needs to be given during school time, this form **MUST** be filled out by your doctor. We **CAN NOT** give **ANY** kind of medication without this permission slip being filled out and signed. Thank You.

Please Type or Print Date: _____

Name of Student/Client: _____ Date of Birth: _____
Address: _____
Name of Medication of Procedure: _____
Date Administration or Treatment or Medication is to Begin: _____
Amount of Medication: _____ Time to be Given: _____
Date When Medication is No Longer Needed: _____
Purpose of Medication: _____
Severe Adverse Reactions that Should be Reported to Physician: _____
_____

Special Instructions (Including Storage, Precautions, etc.): _____
_____

The Nurse will be the ONLY staff member dispensing medication.

_____
Doctors Name- Printed Doctor's Signature

_____
Doctors Address Doctor's Phone Number Doctor's Fax Number

_____

I will deliver the medication to Good Samaritan School. I will notify the school if we change physicians. I will also notify the school if medication, dosage, or procedure is changed or eliminated. Medication must be delivered to school in its original bottle with the prescription label on it and be given to the school nurse.

_____
Parent Signature

_____
Superintendent Signature