Kids Get Arthritis, Too!

Arthritis Foundation®

PERMISSION TO TAKE MEDICATION AT SCHOOL

Date:_____

Student's Name:_____

Grade/Teacher/Homeroom:_____

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

CName 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:_____