Klamath Family Head Start
1940 S. Sixth St. Klamath Falls, OR 97601 | Phone: 541 882-5988 | Fax: 541 884-2803

MEDICATION PERMIT/HEALTH CONDITION

State requirements do not permit schools to administer medications or treatments except to children with chronic and non-communicable conditions with written signed directions of a Physician.

Please provide the following information:

Child's Name: ____ Class #: ________________________

1. Medical Condition:
____

Medication Required: ____ Amount: _______________________

Medication Expiration Date:____

Date to begin medication:__________________________________Date to stop medication _______________

Comments or specific instructions:____

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Medicine must be contained in the original bottle.

If asthma diagnoses please check the following that pertain to child.

Severity Classification	Triggers	
○ Intermittent	○ Colds	○ Smoke
○ Moderate Persistent	○ Weather	○ Exercise
○ Mild Persistent	○ Dust	○ Air Pollution
○ Severe Persistent	○ Animals	○ Food
	○ Other ________________________________	

Last date asthma medication given to child: ____

Physician Signature: _______________________________________M.D. Date: __________________________

Parent/Guardian Signature: _________________________________ Date: __________________________