Permission Form for Prescribed Medication

TO BE COMPLETED BY SCHOOL PERSONNEL

School: _____Date form received: _____

I/we acknowledge receipt of this Statement and Authorization _____

Student Name**:** _____ Date of Birth**:** _____

Grade: _____ Homeroom Classroom: _____

TO BE COMPLETED BY PHYSICIAN OR HEALTH CARE PROVIDER FOR PRESCRIPTION MEDICATIONS

Name of medication: _____

Reason for medication: _____

Form of medication/treatment:

☐ Tablet/capsule ☐ Liquid ☐ Inhaler Injection ☐ Nebulizer ☐ Other _____

Instructions (Schedule and dose to be given at school): _____

_____

Start: ☐ Date form received ☐ Other as specified: _____

Stop: ☐ End of school year ☐ Other date/duration: _____

☐ **For episodic/emergency events only**

Restrictions and/or important side effects: ☐ No restrictions

☐ Yes, Please describe: _____

_____

Special storage requirements: ☐ None ☐ Refrigerate

Other: _____

Physician/Health Care Provider's Signature: _____

Physician/Health Care Provider's Name: _____

Date: _____ Phone: _____ Address: _____

*** For Self-Administration ONLY***For Self-Administration ONLY***For Self-Administration ONLY***

This student has been trained on self-administration of this medication: to be completed for asthmatic, diabetic or severe allergy ONLY.

☐ No ☐ Supervision Required ☐ Supervision not required

This student may carry this medication: ☐ No ☐ Yes

Please indicate if you have provided additional information: ☐ On the back side of this form ☐ As an attachment

Signature: _____ Date: _____

Physician or Authorized Provider

Permission Form for Prescribed Medication

TO BE COMPLETED BY PARENT/GUARDIAN FOR NON-PRESCRIPTION MEDICATIONS

As the parent or legal guardian of the student named below, I authorize my child to take the following over-the-counter medication as noted:

Name of Medication: _____ Dosage/Schedule: _____

Other Information: _____

TO BE COMPLETED FOR ALL MEDICATIONS

I give permission for (name of child) _____to receive the above stated medication(s) at school according to standard school policy. I release and hold harmless the Wolfe County School Board and its employees and agents from any claims or liability connected any injuries or reactions with its reliance on this permission unless such is the result of negligence or misconduct on behalf of the school or its employees.

(Parent/guardian to bring the medication in its original container.)

Date: _____ Signature: _____ Relationship: _____

Home phone: _____ Work phone: _____ Emergency phone: _____

For student health services/procedures not involving medication only, please refer to 09.22 AP.22.

Review/Revised:7/14/11