Permission Form for Prescribed or Over-the-Counter Medication

School: _____ Date form received by the School: _____

Student's Name: _____ **Grade:** _____ **Homeroom/Classroom:** _____

Student's Age: _____ **Date of Birth:** _____

TO BE COMPLETED BY THE PHYSICIAN OR HEALTH CARE PROVIDER FOR PRESCRIPTION MEDICATION

Name of medication: _____ Reason for medication: _____

Form of medication/treatment: ☐ Tablet/capsule ☐ Liquid ☐ Inhaler ☐ Injection ☐ Nebulizer ☐ Other _____

Describe schedule and dose to be given at school: _____

Starting Date: ☐ date form received ☐ Other, as specified: _____

Stopping Date: ☐ for episodic/emergency events only ☐ end of school year ☐ Other date/duration: _____

Restrictions and/or important effects: ☐ Yes. Please describe: _____

NOTE: ***In the event the Principal/designee is notified of the possibility of an adverse or extreme reaction to a medication, s/he shall inform the student's teacher(s) of such a possibility before the student begins the medication schedule.***

Special storage requirements: ☐ None ☐ Refrigerate ☐ Other _____

Student is capable of/responsible for self-administering this medication: ☐No ☐Yes ☐Supervised ☐Unsupervised

Student has been instructed in self-administering the medication: ☐No ☐Yes

Student must carry this medication on his/her person: ☐No ☐Yes

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

_____ _____

Physician/Health Care Provider Signature ***Date***

_____ _____

Signature of Parent/Guardian ***Date***

Name of Physician/Health Care Provider: _____

Address: _____

Phone #: _____ **Fax #:** _____

To the school: Please report concerns about medications or the student's condition to the above physician/health care provider.

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: _____

Permission Form for Prescribed or Over-the-Counter Medication

FOR ALL MEDICATIONS

I give permission for _____ to receive the above medication(s) at school according
Student's Name
to standard school policy and expressly hold harmless, and waive any liability on behalf of, the school or its employees and agents concerning any injuries or reactions resulting from administration of the above medication unless such is the result of negligence or misconduct on behalf of the school or its employees. For on-going medications, I understand that I have the ultimate responsibility for providing the school with an adequate supply of medication to enable orders from a physician or health care provider to be followed.

Date: _____ *Signature:* _____ *Relationship:* _____

Home Phone: _____ *Work Phone* _____ *Emergency Phone* _____

TO BE COMPLETED BY SCHOOL PERSONNEL

I/we acknowledge receipt of the foregoing statement and authorization.

Administrator/designee _____ Date _____

Review/Revised:7/25/06

Permission Form for Prescribed or Over-the-Counter Medication

School: _____ Date form received by the School: _____

Student's Name: _____ **Grade:** _____ **Homeroom/Classroom:** _____

Student's Age: _____ **Date of Birth:** _____

TO BE COMPLETED BY THE PHYSICIAN OR HEALTH CARE PROVIDER FOR PRESCRIPTION MEDICATION

Name of medication: _____ Reason for medication: _____

Form of medication/treatment: ☐ Tablet/capsule ☐ Liquid ☐ Inhaler ☐ Injection ☐ Nebulizer ☐ Other _____

Describe schedule and dose to be given at school: _____

Starting Date: ☐ date form received ☐ Other, as specified: _____

Stopping Date: ☐ for episodic/emergency events only ☐ end of school year ☐ Other date/duration: _____

Restrictions and/or important effects: ☐ Yes. Please describe: _____

NOTE: ***In the event the Principal/designee is notified of the possibility of an adverse or extreme reaction to a medication, s/he shall inform the student's teacher(s) of such a possibility before the student begins the medication schedule.***

Special storage requirements: ☐ None ☐ Refrigerate ☐ Other _____

Student is capable of/responsible for self-administering this medication: ☐No ☐Yes ☐Supervised ☐Unsupervised

Student has been instructed in self-administering the medication: ☐No ☐Yes

Student must carry this medication on his/her person: ☐No ☐Yes

_____ _____

Physician/Health Care Provider Signature ***Date***

_____ _____

Signature of Parent/Guardian ***Date***

By signing above, Parent/Guardian hereby gives consent to the Spencer County Board of Education and its employees and to the child's physician to discuss his or her medical condition or medication administration referenced above.

Name of Physician/Health Care Provider: _____

Address: _____

Phone #: _____ **Fax #:** _____

To the school: Please report concerns about medications or the student's condition to the above physician/health care provider.

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

Over the counter medications given more than 3 consecutive days require a physician's authorization.
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: _____

Permission Form for Prescribed or Over-the-Counter Medication

FOR ALL MEDICATIONS

I give permission for _____ to receive the above medication(s) at school according
Student's Name
to standard school policy and expressly hold harmless, and waive any liability on behalf of, the school or its employees and agents concerning any injuries or reactions resulting from administration of the above medication unless such is the result of negligence or misconduct on behalf of the school or its employees. For on-going medications, I understand that I have the ultimate responsibility for providing the school with an adequate supply of medication to enable orders from a physician or health care provider to be followed.

Date: _____ *Signature:* _____ *Relationship:* _____

Home Phone: _____ *Work Phone* _____ *Emergency Phone* _____

Comments/Special
Instructions: _____

_____

_____

_____

TO BE COMPLETED BY SCHOOL PERSONNEL

I/we acknowledge receipt of the foregoing statement and authorization.

Administrator/designee _____ Date _____

Review/Revised:7/25/06

Permission Form for Prescribed or Over-the-Counter Medication

Student's Name: _____ **Grade:** _____ **Homeroom:** _____ **School:** _____

Student's Age: _____ **Date of Birth:** _____ **Allergies:** _____

TO BE COMPLETED BY THE PHYSICIAN AND PARENT (PRESCRIBED) OR PARENT/GUARDIAN (OVER THE COUNTER)

Policy 09.2241 AP 1 ***(Prescribed Medication)*** *Physician and Parent/Guardian shall complete the required form. All prescription medication, original or refill, shall be sent to school in a pharmacy labeled container which includes the student's name, date dispensed, medication, dosage, strength, date of expiration, and directions for use including frequency, duration, and route of administration, prescriber's name, and pharmacy name, address, and phone number.* ***(Over-the-Counter)*** *Parent/Guardian shall complete the required form. Medication shall be in original container, dated upon receipt and* ***given no more than three consecutive days without signature from the physician****.*

Name of Medication: _____ **Dose:** _____ **Administration Time:** _____

Reason for Medication/Special Instructions: _____

Form of Medication: ☐ Tablet/capsule ☐ Liquid ☐ Inhaler ☐ Nebulizer ☐ Injection ☐ Other _____

Restrictions/Side Effects: ☐ No restrictions ☐ Yes, describe: _____

Starting Date: ☐ Date form received ☐ Other, as specified: _____

Stopping Date: ☐ For episodic/emergency events only ☐ End of school year ☐ Other date/duration: _____

Special storage requirements: ☐ None ☐ Refrigerate ☐ Locked Cabinet ☐ Other _____

Student is capable of/responsible for self-administering this medication: ☐No ☐Yes ☐Supervised ☐Unsupervised
Student has been instructed in self-administering the medication: ☐No ☐Yes
Student must carry this medication on his/her person: ☐No ☐Yes ☐ Backpack (Lifesaving Meds Only)

Physician Signature/Information

_____ _____
Physician/Health Care Provider Signature ***Date***

Printed Name of Physician/Health Care Provider: _____

Address: _____

Phone #: _____ Fax #: _____

Parent/Guardian Consent for all Medications

I give permission for _____ to receive the above medication(s) at school according
Student's Name
to standard school policy and expressly hold harmless, and waive any liability on behalf of, the school or its employees and agents concerning any injuries or reactions resulting from administration of the above medication unless such is the result of negligence or misconduct on behalf of the school or its employees. For on-going medications, I understand that I have the ultimate responsibility for providing the school with an adequate supply of medication to enable orders from a physician or health care provider to be followed.

Parent/Guardian Signature: _____ Date: _____ Relationship: _____

Home Phone: _____ Work Phone _____ Emergency Phone _____

By signing above, Parent/Guardian hereby gives consent to a North Central District Health Department School Nurse, the Spencer County Board of Education and its employees, and to the child's physician/healthcare provider to discuss his or her medical condition or medication administration referenced above.

TO BE COMPLETED BY SCHOOL PERSONNEL

I/we acknowledge receipt of the foregoing statement and authorization.
Administrator/designee _____ Date: _____