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: _____

_____

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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 _____

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

A substantially equivalent electronic form may be used by the District in lieu of this paper form.

Please read carefully. COMPLETE FORM, SIGN, AND DATE. Student should RETURN THIS FORM TO HOMEROOM TEACHER OR SCHOOL BASED HEALTH CENTER. **Consent is for the duration of your child's enrollment in the Newport Independent School District. Consent may be withdrawn at any time by the parent or legal guardian.**

INFORMED CONSENT

I give my consent for _____ _____ _____

Student's Full Name **Birth Date** **Social Security Number**

To receive any of the following services from health care providers or their agents through the school's health center.

1. Physical assessment of acute or chronic illness; assessment of growth and development.
2. Treatment of minor health problems as defined by protocol, including administration of over-the-counter medications such as acetaminophen, ibuprofen, decongestants, etc.
3. Basic laboratory tests when needed to assess problem, such as finger stick for anemia, urine test for bladder or kidney infection, TB skin test, strep screen for sore throat.
4. Health education on nutrition, dental health, physical health concerns, substance abuse, injury prevention & safety.
5. Dental screenings, application of dental sealants, application of dental varnish, and treatment.
6. Mental health counseling, as needed. (School-Based Health Center staff including Family Service of Northern Kentucky school-based services).
7. Other services _____.

_____

You will be notified of health problems identified by Center Staff.

I give consent to the Health Center Staff to review my child's full school record, including attendance and other information that will assist the staff in helping my child. I give Health Center staff permission to share information with school office staff, school nurses, Family Service of Northern Kentucky school-based therapist, and Family Resource and Youth Service Center staff to assist in helping my child. I further consent to have my child participate in ongoing evaluations for the health center program, including questionnaires and surveys. I understand that my child will not be identified by name in the evaluation.

In consenting to services at this facility, I also consent to the performance of tests for human immunodeficiency virus infection (AIDS), hepatitis B, or any other blood-borne infectious diseases if the staff of this facility order the test(s). I understand that the test(s) shall be ordered without specifically notifying me if there are medical findings suggesting a need. I also understand that the test(s) shall be ordered if there are medical findings suggesting a need for the test(s) or if a health care worker is exposed to my child's blood, body fluid, or tissue.

I give my permission for the following hospitals to release to this center the emergency room reports on my child: St. Luke Hospital, St. Elizabeth Hospital, and Children's Hospital of Cincinnati, Ohio. I further give consent for exchange of health information among Health Center Staff Services providers and my child's primary care provider (if listed on the registration form).

I understand by enrolling my child in the Health Center, in accordance with K.R.S. 214.185, out-referrals, to appropriate agencies may be made for diagnostic examination and treatment for venereal disease, pregnancy, alcohol or other drug abuse or addiction without the consent or notification to the parent or guardian.

I understand that certain professionals rendering services at the Health Center are not employees of the School District and are independent contractors.

I hereby give my consent for all services listed above and hereby specifically authorize the release of student health information and personal family information to Health Foundation of Greater Cincinnati and Northern Kentucky University for evaluation purposes.

DATE _____ _____

SIGNATURE OF PATIENT

PATIENT IS:

- ☐ **Emancipated Minor**
- ☐ **Minor** _____ **SIGNATURE OF PARENT, LEGAL AGENT GUARDIAN**
- ☐ Unable to sign because: _____ _____

_____ **RELATIONSHIP TO PATIENT**

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

(This form developed by Newport School Based Health Center)