Permission Form for Prescribed Medication

Student: ______________________ DOB ____________

School: ______________ School Year: ___-___ Allergies: ____________

Grade: _____ Date form received by the School: ____________ Homeroom: ____________

Parent/Guardian: ______________________ Phone: ____________

TO BE COMPLETED BY THE PHYSICIAN OR AUTHORIZED PRESCRIBER

Name of medication (one medication per form): ____________ Dosage: ____________

Administration Instructions (schedule and dose to be given at school) ____________

____

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

Start: ☐ date form received ☐ Other date: ____________

Stop: ☐ end of school year ☐ Other date/duration: ____________

☐ episodic/emergency events only

Restrictions and/or important effects: ☐ None anticipated ☐ Yes. (describe) ____________

Special storage requirements: ☐ None ☐ Refrigerate ☐ Other ____________

X Physician's Signature: ______________________

Physician's Name: ______________________ Phone Number: ____________

Address: ______________________

Please report concerns about medications or disease to the above physician.

Student is capable of/responsible for self-administering this medication:

☐ No ☐ Yes/Supervised by staff ☐ Yes/Unsupervised (Please read and complete statements below.)

Students may carry certain approved, time sensitive, <u>emergency</u> medication on their person (such as inhaler, insulin, Epi-pen, and digestive enzymes). All other medications will be maintained in the school office and supervised by staff. Students may be responsible for self-administration of medications with a signed statement from the physician. Due to his/her medical condition, this student must keep (medication name) ____________ with him/her at all times. In my judgment, this student has shown an adequate level of maturity and is capable of properly self-administering this medication.

X Physician's Signature: ______________________

TO BE COMPLETED BY PARENT/GUARDIAN

I give permission ~~for~~ *(name of child)* ______________________ to receive the above medication at school or on school trips according to standard school policy. (*Schools require parent/guardians to bring the medication in its original container.)* Signing this form shall release, hold harmless, and waive any liability on behalf of the Woodford County School System, the school and its staff members and agents concerning any injuries or reactions resulting from administration of medication to the student unless such is the result of negligence or misconduct on behalf of the school or its employees. I understand that this medication form is valid for the current school year only and will need to be renewed annually.

X Parent/Guardian Signature: ______________________ **Date:** ____/____/____