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: ________________