

Permission Form for Prescribed Medication

TO BE COMPLETED BY SCHOOL PERSONNEL

School: _____ School Year: _____ Date form received: _____
I/we acknowledge receipt of this Physician's Statement and Parent Authorization. _____
Student Name: _____ Student age: _____
Date of birth: _____ Grade: Homeroom/Classroom: _____

TO BE COMPLETED BY PHYSICIAN OR AUTHORIZED PROVIDER

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's Signature _____ Physician's Name: _____

Date: _____ Phone: _____ Address: _____

◆◆◆For Self-Administration ONLY◆◆◆For Self-Administration ONLY◆◆◆For Self-Administration ONLY◆◆◆

Pursuant to KRS 158.832 to KRS 158.836 _____ school permits a student to possess and self-administer asthma or anaphylaxis medication at school and at school-related functions upon completion of the following information by the parent/ guardian and the student's physician and waiver of liability by the parent/guardian.

This student has been instructed on self-administration of this medication: **to be completed for asthmatic, diabetic or severe allergic reaction (anaphylaxis) 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

TO BE COMPLETED BY PARENT / GUARDIAN

I give permission for (name of child) _____ to receive the above stated medication at school according to standard school policy. I release the _____ School Board and its employees from any claims or liability connected with its reliance on this permission. (Parent/guardians to bring the medication in its original container.)

Date: _____ Signature: _____ Relationship: _____

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