Permission Form for Prescribed or Over-the-Counter Medication
Paducah Independent Schools

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

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

TO BE COMPLETED BY THE PARENT/GUARDIAN, PHYSICIAN OR HEALTH CARE PROVIDER.

Procedure 09.2241 AP.1 – (Over-the-Counter) – Parent/Guardians shall complete the required form. Medication shall be in original container, dated upon receipt, and given no more than three (3) consecutive days without signature from physician/health care provider.

(Prescribed Medication) – Parents/Guardians and Health Care Provider shall complete the required form.

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) _____

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

Stopping Date: ☐ end of school year ☐ Other date/duration: _____

As Needed/Emergency events only ☐ Signs/Symptoms of need: _____

Restrictions and/or important side effects: ☐ No restrictions ☐ Yes. Please describe: _____

* 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

**Requires physician/health care provider approval and signature*

_____ _____

Physician/Health Care Provider Signature/Date ***Signature of Parent/Guardian / Date***

Name of Physician/Health Care Provider: _____

Phone #: _____ Fax #: _____

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 or lack of administration of the above medication. 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.

Permission Form Over-the-Counter Medication

PADUCAH INDEPENDENT SCHOOLS

The school nurse's office offers over the counter medications for the students with parent/guardian permission.

- Please indicate below the medications you **permit** your child to have,

This form will keep us from having to call you each time your child needs something different. It will also help us get your child back to class quickly. Thank you for allowing us to care for your child!

☐ **Antacid (Tums/Rolaids)**	☐ **Eye drops (Visine)**	☐ **Oragel**	☐ **Throat spray/lozenge**
☐ **Tylenol**	☐ **Ibuprofen**	☐ **Antibiotic Ointment**	☐ **Antifungal Cream**
☐ **Cough Drops**	☐ **Hydrocortisone Cream 1%**	☐ **Claritin (Loratidine)**	☐ **Calamine Lotion**
☐ **BioFreeze Muscle Rub**	☐ **None of the above**		

- I authorize the nursing staff at Paducah Independent Schools to provide over the counter medication as noted above and as needed to my child.
- I understand that it is my responsibility to directly notify the nursing staff at the school where my child is enrolled of any changes in my child's OTC medication needs.
- I understand that in the event of an adverse reaction to any OTC medication, the medication will be halted and I will be notified by the nursing staff at the school.
- I understand that this permission form will be kept on file in my child's student health record and will not be changed without notification.
- I understand that this document's confidentiality is governed by FERPA (Family Education Rights to Privacy Act) and that all rules under such Act will be followed by all parties.

I 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 or lack of administration of the above medication.

_____

Parent/Guardian Signature

Review/Revised:6/13/2022

Submit