School Year:_____

# Tussey Mountain School District
# Medication Permission Form

**Student Name:_____ Grade:_____ Birthdate:_____**

It is the procedure of the Tussey Mountain School District to administer prescribed medication during school hours only when **absolutely necessary** for the health of the student.

- All medication given MUST have a **parent and physician permission slip** to be given at school.
- Medication must come to school by a parent/guardian in a **prescription bottle** labeled with the child's name, medication name, dose, and time to be given.
- Students are **not permitted** to transport medication to or from school (unless previously authorized by the school nurse).
- Each prescribed medication must have a separate permission form signed by the parent and physician.

## THIS SECTION IS TO BE COMPLETED BY THE PARENT/GUARDIAN

By signing below, I give permission to the school nurse, or other designated person, to administer medication to the child named above in accordance with the physician's instructions. I also give my permission for the school nurse to communicate with my child's physician in regard to this medication/treatment. I release, and hold harmless the Tussey Mountain School District employees from any and all liability and claim whatsoever for the administration of this medication to my child. I understand that this medication must be furnished to the school in accordance with district policy.

Parent's Signature: _____ Date: _____

**For inhaler and EpiPen only:** (please circle below which one your child uses)
I give permission for my child to carry and self-administer his/her prescribed inhaler/epipen
Yes _____ No _____

Parent's signature: _____ Date: _____

## THIS SECTION IS TO BE COMPLETED BY THE PHYSICIAN

Medication:_____ Dose:_____ Frequency: _____

Diagnosis: _____

Duration of medication administration: _____
(all orders expire at the end of current school year)

**Physician's Signature**:_____ **Date**: _____

**For EpiPen or Inhalers only:**
I request this student be allowed to carry and self-administer his/her inhaler/ EpiPen® ☐ Yes ☐ No
As the health care provider for this student, I verify that he/she has been taught proper use of his/her inhaler/ EpiPen®, has adequate knowledge of asthma/anaphylaxis and how to control it, and is thought to be responsible enough to carry his/her inhaler/ EpiPen® and use it properly without supervision.

**Physician's Signature: _____ Date: _____**

Student's self-administration of EpiPen/inhaler approved by:_____, School Nurse

Completed form may be faxed to the school nurse at: 814- 635-3713