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: _____

Modeled after the American Academy of Pediatrics

SCHOOL FORM 6A