Permission Form for Prescribed Medication

To be Completed By School Personnel

SCHOOL:_____SCHOOL YEAR:_____Date received:_____

I/We acknowledge receipt of this Physician's Statement and Parent Authorization_____

To be Completed by Physician ot 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_____Please Printed_____

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 physician and waiver of liability by the parent/guardian.

This student has been instructed on self-administration of this medicine: to be completed for asthmatic, diabtic 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)_____is 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/guardian to bring the medication in its original container)

Signature_____Date_____Relationship_____

Home #_____Work #_____Emerg. #_____