

**Harrison County School Health Clinic
Permission Form for Prescribed Medication**

TO BE COMPLETED BY SCHOOL PERSONNEL

School: _____ School Year: _____ Date form received: _____

I acknowledge receipt of this Physician's Statement and Parent Authorization: _____

TO BE COMPLETED BY PHYSICIAN OR AUTHORIZED PROVIDER

Student Name _____ **Date of Birth** _____

Name of Medication: _____

Reason for Medication: _____

Allergies: _____

Form of Medication: Tablet/Capsule Liquid Inhaler Injection Nebulizer Other _____

Instructions (Schedule and dose to be given at school): _____

Start Date: Date Form Received Other _____

Stop Date: 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 Signature _____ **Physician's Name** _____
Date _____ Phone _____ Address _____

*****FOR SELF ADMINISTRATION ONLY*****

Pursuant to KRS 158.832 to KRS 158-836 Harrison County Schools permits a student to possess and self-administer asthma, diabetes 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: YES NO

Please indicate if you have provided additional information:

On the back side of this form As an attachment

Physician Signature _____ **Date** _____

TO BE COMPLETED BY PARENT/GUARDIAN

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

Date _____ Name: _____ Signature _____

Relationship to Child: _____

Home Phone: _____ Work Phone: _____

Other Emergency Contact Name: _____ Phone: _____