Permission Form for Prescribed or Over-the-Counter Medication

Name: _____ Age: _____ Grade: _____

Homeroom/Classroom: _____ Date of Birth: _____

School: _____ Date form received by the School: _____

Your child's health information is personal and confidential. We are legally required by law to protect the privacy of your child's health information. ***Note: Non-prescriptive medications may not be given to a student for more than three (3) consecutive days unless a doctor orders otherwise.***

List all allergies: _____

_____

List all health problems/concerns: _____

_____

CONSENT FOR MEDICATIONS OR MINOR TREATMENTS

Consent for non-prescriptive medications at school, (if necessary) to relieve minor pain or discomfort.

Ibuprofen (Motrin)	☐ Yes	☐ No	Cough drops/syrup/oral spray	☐ Yes	☐ No
Acetaminophen (Tylenol)	☐ Yes	☐ No	Topical Cream/lotion (anti-itch/antibiotic)	☐ Yes	☐ No
Antacids (Tums/Maalox/Mylanta)	☐ Yes	☐ No	Clean and treat minor scrapes or abrasions	☐ Yes	☐ No
Urine test for bladder/kidney infection*	☐ Yes	☐ No	Finger stick for anemia or diabetes screening*	☐ Yes	☐ No
Benadryl (diphenhydramine) for stings/bites	☐ Yes	☐ No			

PRESCRIBED MEDICATIONS

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

For emergency episodes only: ☐Yes ☐No

Possible reactions: _____

Restrictions and/or important effects: ☐ Yes. Please describe: _____

NOTE: ***In the event the Principal/designee is notified of the possibility of an adverse or extreme reaction to a medication, s/he shall inform the student's teacher(s) of such a possibility before the student begins the medication schedule.***

Special storage requirements: ☐ None ☐ Refrigerate ☐ Other _____

Student is capable of/responsible for self-administering this medication: ☐Yes ☐No ☐Supervised ☐Unsupervised

Student has been instructed in self-administering the medication: ☐Yes ☐No

Student must carry this medication on his/her person: ☐Yes ☐No

Please indicate additional information: ☐ On the back side of this form ☐ As an attachment

Physician/Authorized Prescriber's Signature: _____ **Date:** _____

Physician's Name: _____

Address: _____

Phone #: _____ **Fax #:** _____

TO THE SCHOOL: Please report concerns about medications or the student's condition to the above physician.

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TO BE COMPLETED BY PARENT/GUARDIAN

I give permission for _____ to receive the above medication 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 of the above medication unless such is the result of negligence or misconduct on behalf of the school or its employees. I understand that I have the ultimate responsibility for providing the school with an adequate supply of medication to enable the physician's orders to be followed.

Parent/Guardian Signature: _____ **Date:** _____

Home Phone: _____ *Work Phone* _____ *Emergency Phone* _____

TO BE COMPLETED BY SCHOOL PERSONNEL

I/we acknowledge receipt of the foregoing Physician's statement and Parent's authorization.

Administrator/designee _____ Date _____

Review/Revised:05/20/13