Prescribed Medication Authorization Form

Student Name: _____ Date of Birth: _____

Grade: _____ Homeroom/Classroom: _____ School Year: _____

To Be Completed By Physician/Authorized Provider or School Health Services

Name of Medication: _____

Reason for Medication: _____

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

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

Start: ( ) Date Form Received ( ) Other as specified: _____
Start: ( ) End of School Year ( ) Other date/duration: _____

Restrictions and/or Important Side Effects: ( ) No Restrictions
( ) Yes, Please describe: _____

Special storage requirements: ( ) None ( ) Refrigerate ( ) Other: _____

Physician or Authorized Provider Signature: _____
Date: _____

For Self-Administration

Pursuant to KRS 158.832 to KRS 158.836 Grayson County Schools permit 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 for asthmatic, diabetic, or severe allergic reaction **ONLY.**
( ) No ( ) Supervision required ( ) Supervision not required

Student may carry this medication: ( ) No ( ) Yes

Physician or Authorized Provider Signature: _____ Date: _____

To Be Completed By School Health Services

Date Form Received: _____ School Health Services Signature: _____

To be Completed By Parent/Guardian

I give permission for my child to receive the above stated medication at school according to standard school policy. I release Grayson County Schools and its employees from any claims or liability connected with its reliance on this permission.

Parent/Guardian to bring medication in its ORIGINAL CONTAINER.. My signature will give permission for exchange of verbal and written communication between the physician/authorized provider and the school nurse/health staff regarding my child's medication regimen.

Signature: _____ Date: _____ Telephone: _____