Permission Form for Prescribed Medication, Including Asthma

School_____

Date form received by the school: _____

Student: _____ Date of Birth, or age: _____

Grade: _____ Teacher/Classroom: _____

Medication must be in original container when presented to school.

To be completed by the physician or authorized prescriber:

Reason for medication: _____

Name of medication: _____

Prescribed dosage: _____

Time of day for dosage: _____

Form of medication/treatment:

☐ Tablet/capsule ☐ Liquid ☐ Inhaler ☐ Injection ☐ Nebulizer ☐ Other _____

Possible reactions or side effects of medicine: _____

_____

Start: ☐ Date form received Other date: _____

Stop: ☐ End of school year Other date/duration: _____

☐ For episodic/emergency events only

Restrictions and/or important effects: ☐ None anticipated ☐ Yes Please describe _____

_____

_____

Special storage requirements: ☐ None ☐ Refrigerate

Other:

_____

This student is both capable and responsible for self-administering this medication: (to be completed for asthmatic, diabetic, or severe allergic reaction (anaphylaxis ONLY).

☐ No ☐ Yes, supervised ☐ Yes, unsupervised

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

Date: _____ Signature: _____

Physician's Name: _____ Address: _____ Phone Number: _____	Student has asthma and has been instructed in self-administration of asthma medications. ☐ No ☐ Yes

Permission Form for Prescribed Medication, Including Asthma

To the school: Please report concerns about medications or disease to the above physician.

To be completed by parent/guardian:

I give permission for (*student name)* _____ to receive the above medication at school according to standard school policy.

Signing this form shall release the Laurel County School system and staff members and the Laurel County Health Department registered nurses from any liability of any nature that might result from the administration of medication to the student.

Date: _____ Signature of parent/guardian: _____

Relationship to student: _____

Telephone numbers: Home_____ Work _____

Permission Form for Prescribed Medication, Including Asthma

School_____

Date form received by School_____

Student's Last Name _____ First Name _____ MI _____

Social Security Number _____ Grade _____ Date of Birth _____/_____/_____

Allergies _____

MEDICATION MUST BE IN ORIGINAL CONTAINER WHEN PRESENTED TO SCHOOL.

PARENTAL CONSENT

I am the parent or guardian of _____. I give my permission for him/her to take the following over-the-counter medication (see below). I hereby acknowledge that I have read and understand the Student Code of Acceptable Conduct and Discipline recommendations for distribution of medications to students. I hereby release Laurel County School System and its employees and the Laurel County Health Department registered nurses from any claims or liability connected with its reliance on this permission and agree to indemnify, defend and hold them harmless from any claim or liability connected with such reliance.

_____ _____ _____

Parent/Guardian Signature Daytime Phone Date

Over the counter medications can be given no more than three (3) consecutive days without a physician's order. (09.2241 AP.1)

Student Name: Last	First	MI	Age
Grade	Teacher		

Reason student receiving medication		
Names of Medication	Dosage and how often	Date to Discontinue
Possible reactions		
Form of medication: Tablet Pill Capsule Liquid Inhalant		Other
Feedback to parent required Yes No		How often