Mercer Co. Schools
Permission for Prescribed or Over-the-Counter Medication

Student's Name: _____Date of Birth:_____

Grade: _____ School:_____ Allergies: _____

TO BE COMPLETED BY PHYSICIAN OR AUTHORIZED PRESCRIBER

Name of Medication:_____

Dosage, route, and frequency:_____

Reason:_____

1.) Form of Medication/Treatment:

- ☐ **Tablet/Capsule**
- ☐ **Liquid**
- ☐ **Inhaler**
- ☐ **Nebulizer**
- ☐ **Injection**
- ☐ **Other_____**

2.) Duration of Treatment:

- ☐ **School Year**
- ☐ **Other_____**

3.) Special storage requirements:

- ☐ **Refrigerate**
- ☐ **Other:_____**

4.) Is this student capable of/respsonsible for self-administering this medication?
Yes ___ No____ Supervised___ Unsupervised___

5.) Has the student been instructed in self-administering this medication? Yes_____ No_____

6.) Student must carry this medication on his/her person?
Yes_____ No_____

Provider Printed Name: _____

Provider Signature:_____

Address and Phone:_____

Date:_____

Prescribed medication must be sent to the school in the original labeled container. The first dose of any new medication should be given at home and not at school. When possible, all medication should be brought to the school by a parent or guardian. If medication must be transported to the school by the student who is a bus rider, , it should be transported in the original container and in a sealed envelope with the student's name on the outside and given to the appropriate school personnel (bus driver).

To Be Completed By Parent/Guardian

I give permission for _____ to receive the above medication(s) or treatment at school according 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 as 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. I also give permission for this plan to be available for use in my child's school and for the nurse to contact the physician when necessary to carry out this plan.

Signature of Parent/Guardian: _____ Date: _____

Phone Number(s) of Parent/Guardian: Cell_____ Work_____ Home_____

Other Emergency Contact Name:_____Phone:_____