*****This form should only be used for Inhalers, Epi-pens (for allergic reactions), Glucagon (for diabetic emergencies) and Diastat (for seizures) that students must carry with them per doctors orders. Regular medications may NOT be carried by students.*****

Dear Parent or Guardian,

In order for school personnel to administer any type of medication to your child at school, we must have signed consent from you giving us permission to do so. Certain special medications may be carried by the student for use in emergency situations, but these require parent permission as well as physician authorization. If your child requires that an Asthma inhaler, an Epi-pen (for sever allergic reactions), or a Glucagon injection (for diabetic emergencies) be kept close by, please complete this form with your doctor. Medication should be sent to school in the original container/box with prescription label attached and should have a valid expiration date.

Thank you for your cooperation,

School Health Nurses

Please Note: Medication permission forms are valid for the current school year only. New permission form will need to be filled out by the parents and physician each school year.

Parent/Guardian Authorization:

DATE: _____

STUDENT NAME:_____ PARENT NAME: _____

GRADE:_____ SCHOOL: _____

I hereby request the school personnel of Boyd County Public Schools to allow my child to carry the emergency medication _____ as required for emergency use. I acknowledge that the school District, school, and school personnel hold no liability for any injury or adverse effect sustained by my child from the self-administration of this medication. I further acknowledge that my child knows the proper use of this medication.

PARENT/GUARDIAN SIGNATURE:_____ DATE: _____

PARENT'S PHONE NUMBERS (HOME):_____ (WORK):_____ (CELL):_____

Health Care Provider Authorization:

As the treating health care provider, I authorize that I have prescribed the medication _____ for the above named student for the diagnosed condition of _____. The instructions for administration are _____. The medication should be carried by the student so as to be readily available and self-administered or administered by trained staff when needed.

Possible side effects of this medication could be: _____

I acknowledge that the student knows the proper use of this medication.

Physician Name (please print):_____

Physician Phone Number:_____

******Physician Signature:*** _____ Date:_____

Medication Permission Form #2
Emergency Meds-Student to Carry
(Requires physician signature)