Kenton County School District | *It's about ALL kids.*

09.2241 AP.21

THE KENTON COUNTY BOARD OF EDUCATION
1055 EATON DRIVE, FORT WRIGHT, KENTUCKY 41017
TELEPHONE: (859) 344-8888 / FAX: (859) 344-1531
WEBSITE: www.kenton.kyschools.us
***Dr. Henry Webb*, Superintendent of Schools**

Dear Parent or Guardian,

Any medication, prescription or non-prescription, which a student requires during school hours, should be delivered by a parent/guardian and given to the school nurse or secretary. Any medication shared with another student or found in a student's possession, including his/her backpack or locker, could result in suspension or expulsion. All unauthorized medications will be confiscated.

Please keep in mind that school is not the best place to administer medicines. Doses can be forgotten during the busy school day. If your child's medicine can be administered at home, please do so. Remember, the initial dose of a medication cannot be administered at school.

In order for the school to administer **any** medication to your student, you will need the following:

- *A **Kenton County School District Administration of Medication Permission Form** completed and signed by your child's physician. This form must also be signed by the parent/guardian. This form is available in the school office or first aid room.*
  - *Notes from parents requesting medication to be administered to students will not be accepted.*
  - *We cannot accept telephone permission for medication administration from a physician. Your doctor's office may fax the signed form to the school.*
- *Medication must be in the original container. All prescription medications must have the student's name on the label with directions for administration that match the permission form.*

If the above procedures are not followed, we will not be permitted to administer medication to your student at school.
Medications containing narcotics for pain relief or sedation should not be sent to school. For their own safety, children requiring this level of medication should remain at home until this medication is no longer required during the school day.
All unused medications not picked up from school by a parent within 5 days will be discarded. No medication will be sent home with students.

We appreciate your cooperation in this matter and hope you understand these procedures are for the safety of all of our students.

Review/Revised : 3.14.22

Kenton County School District Administration of Medication Permission Form

SCHOOL: _____ **PHONE:** _____ **FAX:** _____

Dear Parent/Guardian,

If medication administration is required during the school day, whether prescription or non-prescription, this form must be completed and signed by both a physician and parent. For any questions, please contact the school nurse.

All medications are kept in the first aid room and must be in the original container with label affixed. For prescription medication, your student's name must be on the label and the label must match the directions on this form. The initial dose of a medication cannot be administered at school.

Pursuant to *KRS 158.834, 158.838, and 158.836*, the Board of Education policy permits a responsible, trained student to carry and/or self administer medication for asthma (inhaler), severe allergic reaction (injectable epinephrine device), seizures (FDA approved for rescue or symptoms) or diabetes (Glucagon) on his/her person for immediate use in a life-threatening situation with a written physician's order, parent request, school nurse and principal approvals. We accept the parent request and physician statement. We will permit and assist the student to be responsible, but reserve the right to withdraw the privilege if the student shows signs of irresponsible behavior or there is a safety risk. We will contact the parent as soon as possible in this event.

A new form is required for any changes in medication orders. This form may be faxed to the school to the number listed above.

The duration of this form is for one school year only. SCHOOL YEAR:_____.

Name:_____Date of Birth:_____Grade:_____ALLERGIES: _____

TO BE COMPLETED BY PHYSICIAN OR AUTHORIZED PROVIDER

1. Medication:_____Dosage:_____Directions:_____
Administration Time: Lunch ___ or_____Route:_____Diagnosis/Condition:_____
Possible Side Effects:_____Duration: Start_____Stop_____
****In the case of an inhaler, injectable epinephrine device, FDA approved seizure symptom/rescue medication or Glucagon, student has received training to carry the inhaler or emergency medication and, in my opinion, may____CARRY and/or____ SELF ADMINSTER this medication.**
(Physician's Initial) Yes_____

2. Medication:_____Dosage:_____Directions:_____
Administration Time: Lunch ___ or_____Route:_____Diagnosis/Condition:_____
Possible Side Effects:_____Duration: Start_____Stop_____
****In the case of an inhaler, injectable epinephrine device, FDA approved seizure symptom/rescue medication or Glucagon, student has received training to carry the inhaler or emergency medication and, in my opinion, may____ CARRY and/or____SELF ADMINSTER this medication.**
(Physicians Initials) Yes_____

3. Medication:_____Dosage:_____Directions:_____
Administration Time: Lunch ___ or_____Route:_____Diagnosis/Condition: _____
Possible Side Effects:_____Duration: Start_____Stop_____
****In the case of an inhaler, injectable epinephrine device, FDA approved seizure symptom/rescue medication or Glucagon, student has received training to carry the inhaler or emergency medication and, in my opinion, may____CARRY and/or____SELF ADMINSTER this medication.**
(Physicians Initials) Yes_____

******PARENT/GUARDIAN AUTHORIZATION FOR SELF CARRY/SELF ADMINISTER ONLY******

I request that my child, named above, be permitted to:_____carry_____self-administer the above **emergency medication**. I take responsibility for this permission and will ensure the medication is not expired. I understand the medication must be in the original pharmacy container, labeled with name of student, prescribing health care provider, and medication; date of original prescription; strength and dose of medication; and directions for use.

PARENT SIGNATURE **DATE** **STUDENT SIGNATURE** **DATE**

During school hours, I understand teachers, assistants, nurses or other trained school personnel may be administering these medications according to the specified physician's order and District policy. Schools have established individual procedures for where and when the students receive their daily medications. The student has the ultimate responsibility of reporting daily for their medication.

No medications will be sent home with students. All unused medications and medications without orders not picked up from the school by a parent within five (5) days will be discarded.

I give permission for the storage and administration of this medication by trained school personnel accompanying my student on a field trip or school related function in Kentucky and/or other states. In the case of field trips or school related functions, slight variations to the time the medication is administered may also be necessary. Unless indicated otherwise, student may self-administer medication with school trained personnel supervision while on a field trip.

I hereby release the Kenton County Board of Education and its employees from any claims or liabilities connected with their reliance on this permission and agree to indemnify, defend and hold them harmless from any claim or liability connected with such reliance.

***Parent's Signature**	Parent's Phone	Date
***Physician's Signature**	Physician's Phone	Date
***Print Physician's Name**	Physician's Address	Fax Number
Principal's Signature (For self-carry only)	School Nurse Signature	Date Form Rec'd in Office

(7/21)