File: JLCD-E

# PERMISSION FOR MEDICATION

To be completed yearly by a licensed Health Care Provider with prescriptive authority

Student's Name: ________________________________ Date of Birth: _____________Grade:_________
Medication: __________________________________________ Dosage: ________________________
(be specific; no dosage ranges)
School: ______________________________________ Time(s): ________________________________
Route of administration:_________________________________________________________________
Frequency/Special Instructions (if prn, please include time interval between doses):
_____________________________________________________________________________________
_____________________________________________________________________________________
Duration: □ One year □ Other:____________Purpose of Medication: ______________________________
Possible side effects:____________________________________________________________________
**For Epinephrine and inhalers only:** □ Provider gives permission for the student to carry and self-administer the inhaler or Epinephrine device ordered on this form.

**Licensed Health Care Provider:** (Signature)_______________________________________________
**Date:**____________________

**Licensed Health Care Provider:**
(Printed)___________________________________________________________________________

It is agreed and understood that this medication will be provided by the parent/guardian in the original bottle, labeled with the student's name, the name of the medication, dosage, route of administration, and frequency of use. For safety reasons, parents are requested to bring the medication directly to the health office. The parent agrees to pick up expired medication or unused medication within one week of notification by the staff and understands that all medications must be picked up on or before the last day of school for students (medication left at school will be destroyed in accordance with Board of Health Guidelines).

It is understood that the medication is administered solely at the request of and as an accommodation to the undersigned parent/guardian. By signing this document, I give permission for the nurse or nurse designee to administer the medication as prescribed and give my permission for this Health Care Provider to share information about this medication administration with the School Nurse. The undersigned parent(s) or guardian(s) hereby agree(s) to exempt and release the Thompson School District and its directors, officers, employees, volunteers and agents, from any and all liability, claims, demands or actions whatsoever arising out of any damage, loss or injury that my child or I/we might sustain or which they now have or may hereafter have arising out of the administration of the medication to the student.

**Date:**________________________ ___________________________________
**Signature of parent/guardian**

**Note: A Health Care provider order is required to administer all medication in the school setting, including over-the-counter medication.**
In accordance with Board Policy JLCD "Administering Medication to Students," school personnel will not administer prescription or non-prescription medications to students unless the appropriate administration cannot reasonably be accomplished outside of school hours and the student's parent/guardian is not available to administer the medication during the school day.

Adopted September 2021