Permission Form for Prescribed or Over-the-Counter Medication

School:_____ Date form received by school personnel: _____

Student: _____ Date of Birth: _____

Medication Name: _____ Dosage: _____

Known Drug Allergies: _____

Medication Instruction/Time given: _____

Reason for Medication: _____

Prescribing Physician: _____

Address: _____ Phone: _____

MEDICATION HAS TO BE IN ITS ORIGINAL CONTAINER WITH PHARMACY LABEL PRESENT. I ACKNOWLEDGE THE FACT THIS FORM IS ONLY VALID FOR THE CURRENT SCHOOL YEAR.

I give permission for _____(name of child) to receive the above stated medication at school according to the standard school policy. I release the School Board and its employees from any claims of liability connected with its reliance on this permission.

Date:_____ Signature:_____ Relationship:_____

Home number:_____ Work number:_____

BELOW TO BE COMPLETED BY HEALTHCARE PROVIDER

EMERGENCY MEDICATION AUTHORIZATION

This student is capable, responsible, and has demonstrated self-administering the above medication (to be completed for asthma, diabetic or severe allergy ONLY):

☐ **Yes - unsupervised** ☐ **Yes - supervised** ☐ **No**

This student may carry this medication: ☐ **Yes** ☐ **No**

The school nurse will delegate and train designated school personnel to give the above stated emergency medications. Please indicate if you have provided additional information:

☐ **On the back of this form** ☐ **As an attachment**

Signature:_____Date:_____

Physician or Authorized Provider: only valid for the current school year.

****Over-the-counter medication can be given no more than 3 consecutive days without written orders from provider.****

Review/Revised:7/13/2023