

**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