

EXP: _____
Registered On: _____
Entered IC: _____

Prescribed Medication Permission Form, Including Asthma

School: _____ Date form received by the school: _____

Student: _____ Date of Birth, or age: _____

Grade: _____ Teacher/Classroom: _____

Medication must be in original container when presented to school.

To be completed by the physician or authorized prescriber:

Reason for medication: _____

Name of medication: _____

Prescribed dosage: _____ Time of day for dosage: _____

Form of medication/treatment:

☐ Tablet/capsule ☐ Liquid ☐ Inhaler ☐ Injection ☐ Nebulizer ☐ Topical ☐ Other _____

Possible reactions or side effects of medicine: _____

Start: ☐ Date form received ☐ Other date: _____

Stop: ☐ End of school year ☐ Other date/duration: _____

☐ For episodic/emergency events only

Restrictions and/or important effects: ☐ None anticipated ☐ Yes Please describe _____

Special storage requirements: ☐ None ☐ Refrigerate ☐ Other: _____

This student may carry this medication: ☐ Yes ☐ No ☐ Only for transportation: _____

Student has asthma and has been instructed in self-administration of asthma medications. ☐ Yes ☐ No

This student is both capable and responsible for self-administering this medication: (to be completed for asthmatic, diabetic, or severe allergic reaction (anaphylaxis ONLY)). ☐ No ☐ Yes, supervised ☐ Yes, unsupervised

Please indicate if you have provided additional information: ☐ On the back side of this form ☐ As an attachment

Date: _____ DR/NP/PA Signature: _____

PHYSICIAN NAME: _____

ADDRESS: _____

OFFICE: _____ FAX: _____

To the school: Please report concerns about medications or disease to the above physician.

To be completed by parent/guardian:

I give permission for (student name) _____ to receive the above medication at school according to Hancock County School District policy.

Signing this form shall release the Hancock County School District and its employees from any claims or liability connected with its reliance on this permission and agree to indemnify, defend and hold them harmless from any claim or liability connected with such reliance.

Date: _____ Signature of parent/guardian: _____

Relationship to student: _____ Phone numbers: Home _____ CELL _____

Over The Counter Medication Form

EXP: _____
Registered On: _____
Entered IC: _____

SCHOOL _____ DATE FORM RECEIVED BY SCHOOL _____

Student's Last Name _____ First Name _____ MI _____

Grade _____ Teacher/Homeroom: _____ Date of Birth ____/____/____

Allergies _____

MEDICATION MUST BE IN ORIGINAL CONTAINER WHEN PRESENTED TO SCHOOL

PARENTAL CONSENT

I am the parent or guardian of (student name) _____. I give my permission for him/her to take the following over-the-counter medication (see below). I hereby acknowledge that I have read and understand the Student Code of Acceptable Conduct and Discipline recommendations for distribution of medications to students. I hereby release Hancock County School District and its employees from any claims or liability connected with its reliance on this permission and agree to indemnify, defend and hold them harmless from any claim or liability connected with such reliance.

Parent/Guardian Signature _____

Daytime Phone _____

Date _____

Over the counter medications can be given no more than three (3) consecutive days without a physician's order.
(09.2241 AP.1)

Student Name: Last		First	MI	Age
Grade	Teacher			

Reason student receiving medication

Name of Medication

Dosage & How often

Date to Discontinue

Possible reactions

Form of medication:

Tablet

Pill

Capsule

Liquid

Inhalant

Topical

How often

Feedback to parent required

Yes

No

Other Information