Permission Form for Prescribed or Over-the-Counter Medication

TO BE COMPLETED BY THE PHYSICIAN OR HEALTH CARE PROVIDER FOR PRESCRIPTION AND NON-PRESCRIPTION (OVER-THE-COUNTER "OTC") 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: ____________________________________

Fax #:_______________________________________

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.

____ _____________

Physician/Health Care Provider Signature ***Date***

____ _____________

Signature of Parent/Guardian ***Date***

Name of Physician/Health Care Provider: ____

Address:

____

Phone #: _________________________ **Fax #:** __________________________

To the school: Please report concerns about medications or the student's condition to the above physician/health care provider.

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:_________________________

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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:7/10/2024