# Permission Form for Prescribed or Over-the-Counter Medication

School: _____Date form received by the School: _____

**Student's Name: _____ Grade: _____ Homeroom/Classroom: _____**

**Student's Age: _____ Date of Birth: _____**

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

Name of medication: _____ Reason for medication: _____

Form of medication/treatment: ☐ Tablet/capsule ☐ Liquid ☐ Inhaler ☐ Injection ☐ Nebulizer ☐ Other _____

Describe schedule and dose to be given at school: _____

Starting Date: ☐ date form received ☐ Other, as specified: _____

Stopping Date: ☐ for episodic/emergency events only ☐ end of school year ☐ Other date/duration: _____

Special storage requirements: ☐ None ☐ Refrigerate ☐ Other _____

Restrictions and/or important side effects: ☐ No restrictions/side effects ☐ Yes. Please describe:

_____

**NOTE**: ***In the event the Principal/designee is notified of the possibility of an adverse or extreme reaction to a medication, s/he shall inform the student's teacher(s) of such a possibility before the student begins the medication schedule.***

*Pursuant to KRS 158.832 to 158.836, Scott County Schools permits a student to possess and self-administer medications for asthma, diabetes, or anaphylaxis at school and at school-related function upon completion of the following information by the parent/guardian and the student's physician and waiver of liability by the parent/guardian.*

Student has been instructed in self-administering the medication to be completed for asthmatic, diabetic, or severe allergic reactions (anaphylaxis) ONLY: ☐No ☐Supervision Required ☐ Supervision Not Required

Student must carry this medication on his/her person: ☐No ☐Yes

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

_____ _____
***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.

SCHOOL PERSONNEL: PLEASE ENSURE PAGE 2 OF THIS FORM IS ALSO COMPLETED.

# Permission Form for Prescribed or Over-the-Counter Medication

**FOR ALL MEDICATIONS**

I give permission for _____ to receive the above medication(s) at school according
***Student's Name***
to standard school policy and expressly hold harmless, and waive any liability on behalf of, the school or its employees and agents concerning any injuries or reactions resulting from administration of the above medication unless such is the result of negligence or misconduct on behalf of the school or its employees. For on-going medications, I understand that I have the ultimate responsibility for providing the school with an adequate supply of medication to enable orders from a physician or health care provider to be followed.

*Date:* _____ *Signature:* _____ *Relationship:* _____

*Home Phone:* _____ *Work Phone* _____ *Emergency Phone* _____

**TO BE COMPLETED BY SCHOOL PERSONNEL**

I/we acknowledge receipt of the foregoing statement and authorization.

***Administrator/designee*** _____ Date _____