

Medication Consent Forms**PERMISSION FOR ADMINISTERING MEDICATIONS**

Dear Parent or Guardian,

In order for school personnel to administer any type of medication (prescription or over-the-counter) to your child at school, we must first have signed consent from you and your medical provider. Medications must be brought to school by the parent or guardian in its original container with the medication prescription label attached and must have a valid expiration date. **Under no circumstances can medication be brought to school or taken home by the student unless the student has emergency medications and the provider has permitted them to carry.** Please complete all information that is listed below and return the form to school when you bring in the medication.

Please Note: Medication should be given at home if at all possible. The first dose of any new medication will not be given at school. Medication permission forms and medication brought to school are valid for the current school year only. New forms must be filled out and new medication brought in each school year. Medications left at school at the end of the school year will be disposed of if not picked up by the parents.

Parent/Guardian Authorization:

DATE: _____

STUDENT NAME: _____ PARENT NAME: _____

GRADE: _____ SCHOOL: _____

I hereby request the school personnel of Boyd County Public Schools to give the following medications to my child. I acknowledge that the school District, school, and school personnel hold no liability for any adverse effects or side effects resulting from the administration of this medication.

PARENT/GUARDIAN SIGNATURE: _____ DATE: _____

PARENT'S PHONE NUMBERS (HOME): _____ (WORK): _____ (CELL): _____

INSTRUCTIONS

Name of Medication: _____

Dosage: _____

Time of day for dosage: _____

Reason for medication: _____

Reaction or side effects that may occur with this medication: _____

Physician Name (please print): _____

*****Physician Signature: _____

Physician Phone Number: _____

EMERGENCY MEDICATIONS ONLY (inhalers, EpiPen, Glucagon, Seizure medications, etc.) Health Care Provider Authorization: As the treating health care provider, I confirm that I have prescribed the medication. The medication should be carried by the student to be easily accessible for self-administration or administered by trained staff when necessary. I acknowledge that the student understands how to properly use this medication.

Carry and Self-Administer: YES ☐ NO ☐ **Physicians Signature:** _____