Permission Form for Prescribed Medication

TO BE COMPLETED BY SCHOOL PERSONNEL

School: St Joseph School School Year:________ Date form received:________

I/we acknowledge receipt of this Physician's Statement and Parent Authorization.________

Student Name:________ Student age:________ Date of Birth:________

Grade:________ Homeroom/Classroom:________

TO BE COMPLETED BY PHYSICIAN OR AUTHORIZED PROVIDER

Name of medication:________

Reason for medication:________

Form of medication/treatment:

☐ Tablet/capsule ☐ Liquid ☐ Inhaler ☐ Injection ☐ Nebulizer ☐ Other ________

Instructions (Schedule and dose to be given at school):________

Start: ☐ Date form received ☐ Other, as specified:________

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

☐ **For episodic/emergency events only**

Restrictions and/or important side effects: ☐ No restrictions

☐ Yes. Please describe:________

Special storage requirements: ☐ None ☐ Refrigerate

Other:________

Physician's Signature________ Physician's Name:________

Date________ Phone________ Address:________

♦♦♦For Self-Administration ONLY♦♦♦For Self-Administration ONLY♦♦♦For Self-Administration ONLY♦♦♦For Self-Administration ONLY♦♦♦

Pursuant to KRS 158.832 to KRS 158.836 ________ school permits a student to possess and self-administer asthma or anaphylaxis medication at school and at school-related functions upon completion of the following information by the parent/ guardian and the student's physician and waiver of liability by the parent/guardian.

This student has been **instructed** on self-administration of this medication: **to be completed for asthmatic, diabetic or severe allergic reaction (anaphylaxis) ONLY**

☐ No ☐ Supervision required ☐ Supervision not required

This student may carry this medication: ☐ No ☐ Yes

Please indicate if you have provided additional information:

☐ On the back side of this form ☐ As an attachment

Signature:________ Date________

Physician or Authorized Provider

TO BE COMPLETED BY PARENT / GUARDIAN

I give permission for (name of child)________ is to receive the above stated medication at school according to standard school policy. I release the ________ School Board and its employees from any claims or liability connected with its reliance on this permission. (Parent/guardians to bring the medication in its original container.)

Date:________ **Signature:**________ **Relationship:**________

Home phone:________ **Work phone:**________ **Emergency phone:**________

Modeled after the American Academy of Pediatrics