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 Laurel County School District policy.

Signing this form shall release the Laurel 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 ____________

 LCSD/School Health 8/2017

Over The Counter Medication Form

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 Laurel 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**