Madison County School Health Program

Permission Form for Prescribed and Over the Counter Medication

TO BE COMPLETED BY SCHOOL PERSONNEL

School:______________________________ 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 PARENT / GUARDIAN

**********(MUST BE IN CHILD SPECIFIC, CURRENT, ORIGINAL PHARMACY LABELED CONTAINER)**********

Name of medication: ______________________ Reason for medication:______________________

ALLERGIES:______________________ Any OTHER Condition(s):______________________

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**

trictions and/or important side effects: ☐ No restrictions

:s. Please describe:______________________

Special storage requirements: ☐ None ☐ Refrigerate

Other Instructions:______________________

Parent or Guardian Signature______________________ Date:______________

Health Care Provider Name______________________

Address:______________________ Phone:______________ FAX:______________

I give permission for (name of child)______________________ is to receive the above stated medication at school according to standard school policy. I release the Madison County 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 or CELL phone:______________

◆◆◆For Self-Administration and EMERGENCY ◆◆◆For Self-Administration and EMERGENCY ◆◆◆For Self-Administration and EMERGENCY◆◆◆

EMERGENCY MEDICATION AUTHORIZATION

This student is capable, responsible, and demonstrated self-administration of the above medication: **to be completed for asthmatic, diabetic or severe allergy ONLY**

☐ Yes - Unsupervised ☐ Yes-Supervised ☐ No

This student may carry this medication: ☐ Yes ☐ No Any restriction(s):______________________

The school nurse will delegate and train designated school personnel to give the above stated emergency medication.

Please indicate if you have provided additional information:

ı the back side of this form ☐ As an attachment

ıature:______________________ Date______________

Physician or Authorized Provider

****Over the counter medications can be given no more than 3 consecutive days without written orders from health care provider. MCBE 1 (7-2010)

Adapted from the Academy of Pediatrics