

Madison County School District 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

Restrictions and/or important side effects: No restrictions

Yes. 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 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:** _____

TO BE COMPLETED BY Health Care Provider

◆◆◆For Self-Administration or EMERGENCY ◆◆◆For Self-Administration or EMERGENCY ◆◆◆For Self-Administration or EMERGENCY◆◆◆

This student is capable, responsible, and demonstrated self-administration of the above medication:

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 if necessary.

Please indicate if you have provided additional information:

On the back side of this form As an attachment

Signature: _____ **Date** _____

Physician or Authorized Provider