MODEL LABORATORY SCHOOLS
AT EASTERN KENTUCKY UNIVERSITY

Permisssion Form for Prescribed & Over-the-Counter Medication

Student Name: ______________________________ Age: __________ Date of Birth: _________________
Grade: ______________ Homeroom Teacher: ____

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: ____

I give permission for (*name of child*) ______________________________ to receive the above stated medication at school according to standard school policy. I release the Model Laboratory Schools and its' employees from any claims or liability connected with its reliance on this permission.
Health Care Provider Name: ______________________________ Phone: ______________________________
(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*****

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*)

****Over-the-counter medications can be given no mor ethan 3 consecutive days without written orders from Health Care Provider.

Adapted from the Academy of Pediatrics

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