Permission Form for Prescribed or Over-the-Counter Drugs

TO BE COMPLETED BY SCHOOL PERSONNEL

School: _____Date form received: _____

I/we acknowledge receipt of the Health Care Provider's Statement and/or Parent's Authorization.

Signature: _____

Student's Name: _____ Student's Age: _____ Date of Birth: _____

Grade: _____ Homeroom/Classroom: _____

TO BE COMPLETED BY PARENT/GUARDIAN

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 effects: ○ No restrictions

○ Yes. Please describe: _____

_____

Special storage requirements: ○ None ○ Refrigerate ○ Other_____

Health Care Provider Name _____

Address: _____ Phone: _____ FAX _____

I give permission for _____ to receive the above medication at school according to standard
Student's Name

school policy and expressly hold harmless, and waive any liability on behalf of, the school or its employees and agents concerning any injuries or reactions resulting from administration of the above medication unless such is the result of negligence or misconduct on behalf of the school or its employees. For on-going medications, I understand that I have the ultimate responsibility for providing the school with an adequate supply of medication to enable orders from a physician or health care provider to be followed.

Date: _____ Signature: _____ Relationship: _____

Home phone: _____ Work phone: _____ **Emergency phone: _____**

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PHYSICIAN OR AUTHORIZED HEALTHCARE PROVIDER ORDERS

For Self Administration of Medication

This student is capable, responsible, and has demonstrated self-administering the above medication

○ **Yes -** Unsupervised ○ **Yes –** Supervised ○ **No** This student should not self-carry medication

This student may self-carry this medication: ○ **Yes** ○ **No**

Note: the school nurse will also delegate and train unlicensed school personnel to give any emergency medication.

Signature: _____ Date _____

Physician or Authorized Provider: only valid for the current school year

For over-the-counter medication to be given more than 3 consecutive days

******Over-the-counter medications can only be given more than (3) consecutive days with written orders from a health care provider**

Signature: _____ Date _____

Physician or Authorized Provider: only valid for the current school year

A substantially equivalent electronic form may be used by the District in lieu of this paper form.

Review/Revised:7/27/2021