Permission Form for Prescribed Medication

TO BE COMPLETED BY SCHOOL PERSONNEL

School: Holy Name School School Year: 2014-20 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 PHYSICIAN OR AUTHORIZED PROVIDER

Name of medication: _____

Reason for medication: _____

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: _____

Physician's Signature _____ Physician's Name: _____

Date _____ Phone _____ Address: _____

To be completed by physician or authorized provider

Pursuant to KRS 158.832 to KRS 158.836 _____ school permits a student to possess and self-administer asthma or anaphylaxis medication at school and at school-related functions upon completion of the following information by the parent/ guardian and the student's physician and waiver of liability by the parent/guardian.

This student has been instructed on self-administration of this medication: to be completed for asthmatic, diabetic or severe allergic reaction (anaphylaxis) ONLY

☐ No ☐ Supervision required ☐ Supervision not required

This student may carry this medication: ☐ No ☐ Yes

Please indicate if you have provided additional information:

☐ On the back side of this form ☐ As an attachment

Signature: _____ Date _____

Physician or Authorized Provider

TO BE COMPLETED BY PARENT / GUARDIAN

I give permission for (name of child) _____ is to receive the above stated medication at school according to standard school policy. I release the Holy Name 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 phone: _____

Modeled after the American Academy of Pediatrics