# Permission Form for Prescribed Medication

**TO BE COMPLETED BY SCHOOL PERSONNEL**

School:_____ School Year:_____ 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:_____

♦♦♦**For Self-Administration ONLY**♦♦♦**For Self-Administration ONLY**♦♦♦**For Self-Administration ONLY**♦♦♦**For Self-Administration ONLY**♦♦♦

*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 _____ 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**