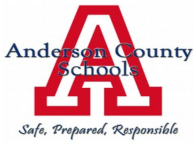

Permission Form for Prescribed and Over the Counter Medication

TO BE COMPLETED BY SCHOOL NURSE

School: ______________________________ Grade/Teacher ______________ Date form received: ______________

I/we acknowledge receipt of this Physician's Statement and/or Parent Authorization. ______________________________

TO BE COMPLETED BY PARENT / GUARDIAN

Student's Name: ______________________________ **Date of birth:** ______________________

Name of medication: ______________________________ **Reason for medication:** ______________

Form of medication/treatment **Medication ALLERGIES:** ______________

☐ Tablet/capsule ☐ Liquid ☐ Inhaler ☐ Injection ☐ Nebulizer ☐ Other ______________

INSTRUCTIONS: **MUST BE COMPLETE**

*** DOSAGE:** ______________________ *** TIME TO BE GIVEN:** ______________________

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: ______________________

Health Care Provider Name ______________________________ Phone ______________

Address ______________________________ Fax: ______________

I give permission for myself/my child to receive the above medication at school according to standard school policy and local PHPR. I release the Anderson County Health Department and the Anderson County School Board and its employee's from any claims or liability connected with its reliance on the permission. My signature will give permission for exchange of verbal and written communication between the Health Care Provider and the school nurse regarding my child's medical regime.

Signature of Parent or Guardian: ______________________ Relationship: ______________ Date: ____________

Home phone ______________ Work Phone ______________ Cell Phone ______________

♦♦♦**For Self-Administration and EMERGENCY** ♦♦♦**For Self-Administration and EMERGENCY** ♦♦♦**For Self-Administration and EMERGENCY**♦♦♦

EMERGENCY MEDICATION AUTHORIZATION

TO BE COMPLETED BY PHYSICAIN /HEALTHCARE PROVIDER

This student is capable, responsible, and demonstrated self-administration of the above medication: **to be completed for asthmatic, diabetic or severe allergy ONLY**

☐ **Yes - Unsupervised** ☐ **Yes-Supervised** ☐ **No**

This student may carry this medication: ☐ **Yes** ☐ **No**

The school nurse will delegate and train designated school personnel to give the above stated emergency medication.

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 more than 3 consecutive days without written orders from health care provider.*

Adapted from the Academy of Pediatrics

ACBOE 1 (6/12)