Permission Form for Prescribed Medication

TO BE COMPLETED BY SCHOOL PERSONNEL

School: INNOCADEMY ALLEGAN CAMPUS 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 IAC 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

fax to: 269-561-4052