

Madison County School Health Program
Permission Form for Prescribed and Over the Counter Medication

TO BE COMPLETED BY SCHOOL PERSONNEL

School: _____ 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 PARENT / GUARDIAN

*******(MUST BE IN CHILD SPECIFIC, CURRENT, ORIGINAL PHARMACY LABELED CONTAINER)*******

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 Instructions: _____

Parent or Guardian Signature _____ **Date:** _____
 Health Care Provider Name _____
 Address: _____ Phone: _____ FAX: _____

I give permission for (name of child) _____ is to receive the above stated medication at school according to standard school policy. I release the Madison County 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 or CELL phone:** _____

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EMERGENCY MEDICATION AUTHORIZATION

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** **Any restriction(s):** _____
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