<u>MEDICATIONS</u>

Prescription medications, to be given at school, must have a school medication form signed by a prescribing doctor and parent/guardian. Please have this form completed by the first day of school. Medications cannot be brought to school by students. **<u>NO</u>** medications will be accepted without this form. Medications must be in the original prescription bottle with student's name and dose to be given in school. This includes daily medications, inhalers, epi-pens, seizure medications as well as short term medications (antibiotics, steroids, etc). If a student has a short term medication without the required physician form, a parent/guardian will have to administer the medication at the school themselves or appoint a family member/friend to come to school and administer the medication.

Epi-pens, inhalers and seizure medications require a health/emergency action plan to be completed and returned with medications. Packets for asthma, bee venom/food allergy, and seizures as well as daily medications can be found on our website.

Permission Form for Prescribed 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 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 restriction

☐ 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

This student has been trained on self-administration of this medication: to be completed for asthmatic, diabetic or severe allergy 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 Bracken 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 phone: __________