

Authorization to Give Prescription and/or Over-the-Counter Medication

Student Name: _____ Student Age: _____ Date of Birth: _____
Grade: _____ Homeroom/Classroom: _____ Allergies _____

TO BE COMPLETED BY PHYSICIAN OR AUTHORIZED PROVIDER

Name of medication: _____
Reason for medication: _____

Tablet/capsule Liquid Inhaler Injection Nebulizer Other _____

Instructions (Schedule & 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 For specified field trip only _____

Restrictions and/or important side effects: No restrictions Yes. Please describe: _____

Special storage requirements: None (Unless otherwise stated, medication will be kept locked in office)

Classroom Refrigerate Other: _____

Physician's Signature: _____ Physician's Name: _____

Date: _____ Phone: _____ Address: _____

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

Pursuant to KRS 158.832-KRS 158.836, Eminence Independent Schools permit 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: Yes No

Supervision required Supervision not required

This student may carry this medication: Yes No

Please indicate if you have provided additional information:

On the back of this form As an attachment

Physician's Signature: _____ Physician's Name: _____

TO BE COMPLETED BY PARENT/GUARDIAN

I give my permission for my child to receive the above medication at school according to school policy and expressly waive any liability on behalf of Eminence Independent Schools and school personnel as a result of the administration of the above medication. I understand that I have the ultimate responsibility for providing the school with an adequate supply of medication to enable the physician's orders to be followed.

Parent Signature _____ Relationship to child: _____

Date: _____ Home phone: _____ Work phone: _____ Cell phone: _____

Emergency Contact: _____ Phone _____

TO BE COMPLETED BY SCHOOL PERSONNEL

School _____ School Year _____ Date form received _____

I/We acknowledge receipt of this Physician's Statement and Parent Authorization _____

For student health services/procedures not involving medication only, please refer to 09.22 AP.22