

**Permission Form for Prescribed Medication**

**TO BE COMPLETED BY SCHOOL PERSONNEL**

School: \_\_\_\_\_ 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 \_\_\_\_\_ 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: \_\_\_\_\_