Grace Community Health Center &
Corbin Independent Schools

Permission Form for Prescription Medication

School: _____ Date form received by the school: _____

Student's Name: _____ **Grade**: ___ **Homeroom/Classroom**: _____

Student's Age: _____ **Date of Birth**: _____

TO BE COMPLETED BY THE PHYSICIAN OR HEALTH CARE PROVIDER FOR PRESCRIPTION MEDICATION

Name of medication: _____Reason for medication:_____

Form of medication/treatment: __Tablet/capsule __Liquid __Inhaler__Injection__Nebulizer__Other___

Describe schedule and dose to be given at school: _____

Starting Date: __date for received __ other, as specified:_____

Stopping Date: __for episode/emergency events only __end of school year __other date/duration_____

Restrictions and/or important effects: __Yes. Please describe:_____

Note: In the event the Principal/designee or School Nurse is notified of the possibility of an adverse or extreme reaction to a medication, s/he shall inform the student's teacher(s) of such a possibility before the student begins the medication schedule.

Special storage requirements: __None __Refrigerate __Other_____

Student is capable of/responsible for self-administering the medication: __No __Yes __Supervised __Unsupervised

Student has been instructed in self-administering the medication: __No __Yes

Student must carry this medication on his/her person: __No __Yes

Please indicate additional information: __On the back side of this form __As an attachment

_____ _____
Physician/Health Care Provider Signature Date

_____ _____
Signature of Parent/Guardian Date

Name of Physician/Health care Provider:_____

Address:_____

Phone#_____ Fax#_____

To the school: Please report concerns about the medications or the student's condition to the above physician/health care provider.

TO BE COMPLETED BY THE PARENT/GUARDIAN FOR NON-PRESCRIPTION MEDICATIONS

As the parent of legal guardian of the student named below, I authorize my child to take the following over-the-counter medication as noted:

Name of Medication: _____ Dosage/Schedule:_____Other Information: _____

Permission Form for Prescribed or Over –the –Counter Medication

FOR ALL MEDICATIONS

I give permission for _____to receive the above medication(s) at school according to standard school policy and expressly hold harmless, and waive any liability on behalf of, the school or its employees and agents concerning any injuries or reactions resulting from administration of the above medication unless such is the result of negligence or misconduct on behalf of the school or its employees. For on-going medications, I understand that I have the ultimate responsibility for providing the school with an adequate supply of medication to enable orders from the physician of health care provider to be followed.

Date: _____ *Signature:* _____ *Relationship:* _____

Home Phone: _____ *Work Phone:* _____ *Emergency Phone:* _____

TO BE COMPLETED BY SCHOOL PERSONNEL / SCHOOL NURSE

I/we acknowledge receipt of the foregoing statement and authorization.

Administrator/designee OR School Nurse_____ Date_____