Board Policy: JHCD-AF2

ADMINISTRATION OF MEDICATIONS TO STUDENTS

(Permission Form for Medications)

Please attach any additional information the district might need to have in an emergency.

School: _____ Date Form Received by the School: _____

Student Information

Name: _____ Age: _____ Date of Birth: _____

Homeroom/Classroom: _____ Grade: _____

Medication/Prescription Information

_____ Prescription Medication _____ Over-the-Counter Medication Provided by Parent/Guardian

Has the student been given the first dose of this medication? _____ Yes _____ No

Name of Medication: _____

Reason for Medication: _____

Form of Medication/Treatment: _____ Tablet/Capsule _____Liquid _____Inhaler
_____Injection _____Nebulizer _____Other:

Describe the schedule and dose to be given at school: _____

If "as needed," indicate the maximum dosage per day: _____

Are there restrictions and/or important side effects? _____ Yes _____ No

If yes, please describe: _____

Special Storage Requirements: _____ None _____ Refrigerate _____ Other:

Physician's Information:

Physician's Name: _____

Address: _____

Phone: _____ Fax: _____

Parental Permission

I give permission for _____ (student's name) to receive the above medication at school.

I also give district employees permission to contact the student's physician directly to provide information on the student's condition or clarify medication administration instructions. I understand that I have the ultimate responsibility for providing the school with an adequate supply of medication and for informing the school district immediately if any information provided on this form changes or if administration of medication should cease.

Signature: _____ Date: _____

Relationship: _____

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

Note: The reader is encouraged to review policies and/or procedures for related information in this administrative area.

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