WARREN COUNTY PUBLIC SCHOOLS

Permission Form for Prescribed Medication

TO BE COMPLETED BY PARENT OR LEGAL GUARDIAN

Student:_____ School:_____ School Year:_____

Student age:_____ Date of Birth:_____ Grade:_____ Homeroom/Classroom:_____

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

If yes, please describe:_____

_____

Special storage requirements: None Refrigerate

Other:_____

Physician's Name_____

Date_____ Phone_____ Address:_____

TO BE COMPLETED BY PARENT / GUARDIAN

I give permission for (name of child)_____ to receive the above stated medication at school according to standard school policy. I release the Warren County Board of Education 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:**_____

*Date:*_____	*Number of pills received:*_____	*Initials:*_____
*Date:*_____	*Number of pills received:*_____	*Initials:*_____
*Date:*_____	*Number of pills received:*_____	*Initials:*_____
*Date:*_____	*Number of pills received:*_____	*Initials:*_____
*Date:*_____	*Number of pills received:*_____	*Initials:*_____
*Date:*_____	*Number of pills received:*_____	*Initials:*_____
*Date:*_____	*Number of pills received:*_____	*Initials:*_____

I/we acknowledge receipt of this Physician's Statement and Parent Authorization:

Authorized School Personnel Signature:_____