FILE: JHCD-AF2
Critical

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's Information

Name: _____ Age: _____ Date of Birth: _____

Homeroom/Classroom: _____ Grade: _____

Medication/Prescription Information

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

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

Name of Medication: _____

Reason for Medication: _____

_____

Form of Medication/Treatment: G Tablet/Capsule G Liquid G Inhaler

G Injection G Nebulizer G 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? G Yes G No

If yes, please describe: _____

Special Storage Requirements: G None G Refrigerate G 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: _____

Notice

Schools in this district are equipped with pre-filled epinephrine auto syringes and asthma-related rescue medications that can be administered by the school nurse or other trained personnel in the event of life-threatening emergencies involving anaphylaxis or asthma.

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

Implemented: 12-13-1999

Revised: 03-14-2013

Tri-County RVII School District; Jamesport MO