

PICKERINGTON LOCAL SCHOOL DISTRICT

PERMISSION FORM FOR PRESCRIBED MEDICATION
GRADES 7-12

Student Name: _____ Grade _____
Date form received by the school: _____
Date medication received by the school: _____
Student's Date of Birth: _____ School Building: _____

TO BE COMPLETED BY THE PHYSICIAN OR LICENSED PRESCRIBER:

Reason for medication: _____
Name of medication: _____
Schedule and Dose: _____
Form of medication: _____

Start: [] date form received Other date: _____
Stop: [] end of current school year Other date/duration: _____
[] for episodic/emergency events only

Restrictions and/or important side effects: [] None anticipated [] Yes (Describe below)

Any severe adverse reactions that should be reported to the physician _____

Special Instructions for Administration of Drug Including Sterile Conditions and Storage

Special storage requirements [] None [] Refrigerate [] Sterile Conditions
Other: _____

Special Instructions for Administration (use attachment if desired) _____

This student is both capable and responsible to carry and self-administer this medicine:
[] No [] Yes

Please indicate if you have provided additional information:

[] On the back side of this form [] As an attachment

Date: _____ Signature of Physician or licensed prescriber: _____

Physicians Name (Print): _____
Address: _____
Phone Number: _____ Fax Number: _____

To the School: Please report concerns about medications or disease to the above physician or licensed prescriber.

TO BE COMPLETED BY PARENT/GUARDIAN

I give permission for (name of child) _____ to receive the above medication at school according to standard school policy. School policy requires that only one day's supply of medication (exception: inhaler/nebulizer) be carried on a daily basis. Also, medication must be carried in its original container. I will provide written documentation, signed by a physician or licensed prescriber, if any of the information listed above changes. I hereby release all Board employees and the Board of Education from liability for damages or injury resulting directly/indirectly from this authorization. I hereby authorize the exchange of any information as related to this prescription drug concerning my child between Pickerington Local School District and the above physician or licensed prescriber.

Parent/Guardian Signature

Parent/Guardian Name (print)

Parent/Guardian Phone Number

For Asthma Inhalers Only

Procedure to follow in the event that medication does not produce the expected relief from student's asthma attack: _____

Adverse reactions for unauthorized user: _____

Other Special Instructions: _____

Student has been instructed on proper use of inhaler and is responsible to carry inhaler and self administer:

Yes No *We request a duplicate inhaler be provided for availability in the clinic.*

Parent/Guardian Signature _____

Licensed Prescriber Signature _____

Adopted: 06/28/94
Revised: 12/08/97
Revised: 01/07/02