Alcoa City Schools Permission Form for Prescribed Medication

STUDENT INFORMATION

Student Name_____ Date of Birth_____ School Year_____

School_____ Grade_____ Teacher_____

List any known food/drug allergies or reactions_____

PRESCRIBER AUTHORIZATION (To be completed by Physician/Authorized Prescriber)

Name of Medication_____ Reason for Medication_____

Form of Medication/Treatment: ☐ Tablet/capsule ☐ Liquid ☐ Inhaler ☐ Injection ☐ Nebulizer ☐ Other _____ Dosage: _____

Start Date:_____ Stop Date: _____ Time to be Given: _____

Restrictions and/or important effects: ☐ None anticipated ☐ Yes (Please describe)_____

_____

This student is both capable and responsible for self-administering this medication: ☐ NO ☐YES/Supervised ☐ YES/Unsupervised

For emergency reasons this student must carry this medication with them at all times at school: ☐ NO ☐ YES

Please indicate if you have provided additional information: ☐On the back side of this form ☐ As an attachment

Prescriber's Name_____ Phone Number_____

Address_____ Fax Number_____

Prescriber's Signature_____ **Date**_____

TO BE COMPLETED BY PARENT/GUARDIAN

Parent Name_____ Home Phone:_____ Work Phone:_____

Emergency Contact Person Name_____ Phone:_____

I attest that my child, _____, is competent, thus, I hereby give consent for my child to be assisted in taking the medication described above during school hours by the school nurse. I understand that this authorization shall be effective for the current_____ school year and must be renewed annually. I understand that if any changes in the medication order occur during the school year, a new form must be completed and returned to the school. Medication must be registered with the principal, school designee or the school nurse. It must be in the original container with a proper prescription label with the student's name, prescriber's name, date of prescription, name of medication, dosage, strength, time interval, route or administration and the date of expiration when appropriate. Additionally, I hereby give permission for trained unlicensed ACS personnel to assist with the self administration of prescription medication, excluding insulin, as ordered by my child's physician in the absence of the school nurse. As the parent/legal guardian, I shall indemnify and hold harmless the school, the agents of the school, and the local board of education against any claims related to the self administration of medication.

Parent/Guardian Signature_____ **Date**_____