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President

American Community Schools of Athens

Permission Form for Prescribed and Over the Counter Medication

TO BE COMPLETED BY SCHOOL PERSONNEL

School: _____ Date form received: _____

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

Student Name: _____ Student age: _____ Date of Birth: _____

Grade: _____ Homeroom/Classroom: _____

TO BE COMPLETED BY PARENT / GUARDIAN

********** (MUST BE IN CHILD SPECIFIC, CURRENT, ORIGINAL PHARMACY LABELED CONTAINER) **********

Name of medication: _____ **Reason for medication:** _____

ALLERGIES: _____ **Any OTHER Condition(s):**_____

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. Please describe: _____

_____

Special storage requirements: None Refrigerate

Other Instrructions:_____

Parent or Guardian Signature _____ Date:_____

Health Care Provider Name_____

Address:_____ Phone:_____ FAX:_____

I give permission for (name of child) _____ is to receive the above stated medication at school according to standard school policy. I release the School Board 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 or CELL phone:** _____

TO BE COMPLETED BY Health Care Provider

□□□**For Self-Administration or EMERGENCY** □□□**For Self-Administration or EMERGENCY** □□□**For Self-Administration or EMERGENCY**□□□

This student is capable, responsible, and demonstrated self-administration of the above medication:

Yes - Unsupervised ☐ **Yes-Supervised** ☐ **No** ☐

This student may carry this medication: **Yes** ☐ **No** ☐ **Any restriction(s):**_____

The school nurse will delegate and train designated school personnel to give the above stated emergency medication if necessary.

Please indicate if you have provided additional information:

On the back side of this form As an attachment

Signature:_____ Date_____

Physician or Authorized Provider

******Over the counter medications can be given no more than 3 consecutive days without written orders from health care provider.**

Adapted from the Academy of Pediatrics

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