

Permission Form for Prescribed and Non-Prescribed Medication

TO BE COMPLETED BY SCHOOL PERSONNEL

School: Valley Lutheran High School School Year: 20__ Date Form Received: __
I/we acknowledge receipt of this Physician's Statement and Parent Authorization: __

Student Name: __ Student age: __ Date of Birth: __ Grade: __

TO BE COMPLETED BY PHYSICIAN OR AUTHORIZED PROVIDER FOR OVER THE COUNTER AND PERSCRIBED MEDICATION

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 Please describe: __

Special storage requirements: None Refrigerate

Other: __

Physician's Signature: __ Physician's Name Printed: __

Date: __ Phone: __ Address: __

*** For Self-Administration ONLY***** For Self-Administration ONLY***** For Self-Administration ONLY***** For Self-Administration ONLY***

Pursuant to KRS 158.832 to KRS 158.836 Valley Lutheran High School permits a student to possess and self-administer asthma or anaphylaxis medication at school and at school-related functions upon completion of the following information by the parent/guardian and the student's physician and waiver of liability by the parent/guardian.

This student has been instructed in self-administration of this medication: to be completed for asthmatic, diabetic or severe allergic reaction (anaphylaxis) ONLY

- No Supervision required Supervision NOT required

This student may carry this medication: No Yes

Please indicate if you have provided additional information:

- On the back side of this form As an attachment

Signature: __ Date: __

Physician or Authorized Provider

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 Valley Lutheran High School, School Board, and all 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: __/__/20__ Signature: __ Relationship: __