Shelby County Public Schools

AUTHORIZATION TO GIVE PRESCRIPTION OR OVER-THE-COUNTER MEDICATION

Student Name: _____Student Age: _____Date of birth: _____
Grade:_____ Homeroom/Classroom:_____

TO BE COMPLETED BY PHYSICIAN OR AUTHORIZED PROVIDER

Name of medication: _____
Reason for medication: _____
[ ] Tablet/capsule [ ] Liquid [ ] Inhaler [ ] Injection [ ] Nebulizer [ ] Other: _____
Instructions: (schedule and dose to be given at school): _____
_____
Start: [ ] Date form received [ ] Other as specified: _____
End: [ ] 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 (print):_____
Date: _____Phone: _____Address: _____

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

TO BE COMPLETED BY PHYSICIAN OR AUTHORIZED PROVIDER

Pursuant to KRS 158.832 to KRS 158.836 Shelby County Public Schools permit 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.

To be completed for asthmatic, diabetic or severe allergic reaction (anaphylaxis) ONLY:
This student has been instructed on self-administration of the above named medication:
[ ] No [ ] Supervision required [ ] Supervision Not Required
This student may carry this medication: [ ] Yes [ ] No
Please indicate if you have provided additional information:
[ ] On the back of this form [ ]As an attachment
Physician Signature: _____ Date: _____
Physician's Name (print): _____

TO BE COMPLETED BY PARENT/GUARDIAN

I give my permission for my child to receive the above medication at school according to school policy and expressly waive any liability on behalf of Shelby County Public Schools and school personnel as a result of the administration of the above medication. I understand that I have the ultimate responsibility for providing the school with an adequate supply of medication to enable the physician's orders to be followed.
Parent Signature: _____ Date: _____
Relationship to child: _____
Home Phone: _____ Work Phone: _____ Cell Phone:_____

TO BE COMPLETED BY SCHOOL PERSONNEL

School: _____School year: _____Date form received: _____
I/We acknowledge receipt of this Physician's Statement and Parent Authorization: _____