Frankfort Independent School Health Program
Permission Form for Prescribed and Over the Counter Medication

TO BE COMPLETED BY SCHOOL NURSE

School: ___________________________________________ Grade: __________ Date form received: ______________________________

I/we acknowledge receipt of this Physician’s Statement and/or Parent Authorization.___________________________________________________________________

TO BE COMPLETED BY PARENT / GUARDIAN

Student’s Name: ___________________________________________ Date of birth: _______________________

Name of medication: ___________________________________________ Reason for medication:____________________

Form of medication/treatment

☐ Tablet/capsule ☐ Liquid ☐ Inhaler ☐ Injection ☐ Nebulizer ☐ Other _______________________

Instructions:
Dosage: ________________________________________  Time: ___________________________________

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 Instructions: ________________________________

Health Care Provider Name ____________________________________________ Phone ______________________

Address __________________________________________________________________ Fax: ________________________

I give permission for myself/my child to receive the above medication at school according to standard school policy and local PHPR. I release the Franklin County Health Department and the School Board and its employee’s from any claims or liability connected with its reliance on the permission. My signature will give permission for exchange of verbal and written communication between the Health Care Provider and the school nurse regarding my child’s medical regime.

Signature of Parent or Guardian: ____________________________________________ Date: ___________

Home phone ________________________  Work Phone _______________________Cell Phone ________________________

TO BE COMPLETED BY PHYSICIAN/HEALTHCARE PROVIDER

This student is capable, responsible, and demonstrated self-administration of the above medication: to be completed for asthmatic, diabetic or severe allergy ONLY

☐ Yes - Unsupervised ☐ Yes-Supervised ☐ No

This student may carry this medication: ☐ Yes ☐ No

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

Please indicate if you have provided additional information:

☐ On the back side of this form  ☐ As an attachment

Signature: ____________________________________________ Date ______________________________

Physician or Authorized Provider

***For Self-Administration and EMERGENCY  ◆◆◆For Self-Administration and EMERGENCY ◆◆◆◆For Self-Administration and EMERGENCY◆◆◆◆

EMERGENCY MEDICATION AUTHORIZATION

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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