PRSD 2.04

PERMISSION FORM FOR PRESCRIBED MEDICATION

PINE-RICHLAND SCHOOL DISTRICT

Date form received by the school:_____

Student:_____ Date of birth, or age:_____

Grade:_____ Teacher/Classroom:_____

To be completed by the physician or authorized prescriber.

Reason for medication:_____

Name of medication:_____

Instructions (Schedule and dose to be given at school):_____

_____

Start: ☐ date from received Other date:_____ ☐ For episodic/emergency events only
Stop: ☐ end of school year Other date/duration: _____

Restrictions and/or important side effects: ☐ None anticipated.

☐ Yes. Please describe:_____

_____

This student is both capable and responsible for self-administering this medication (for inhaler and epi-pen use only)
☐ No ☐ Yes – Supervised ☐ Yes-Unsupervised (Pending decision of Nurse)***

This student may carry this medication: ☐ Yes ☐ No

Date: _____ Signature: _____ M.D. D.O.
(Physician's Signature)

Physician's Name: _____

Address:_____

Phone Number: _____

To be completed by parent/guardian:
I give permission for (name of child) _____ to receive the above medication at school according to standard school policy.

***If the above medication is to be carried and self administered by the above named child, I acknowledge that the school bears no responsibility for ensuring that the medication is taken, and I relieve the school district and its employees of responsibility for the benefits or consequences of the prescribed medication. I am aware than any improper use/sharing of the above mentioned medication will result in immediate confiscation of the inhaler and loss of the privilege to self-administer

Our school district requires parent/guardians to bring the medication in its original container.

Date: _____ Signature:_____ Relationship:_____

ASTHMA INHALERS – SELF-ADMINISTRATION BY STUDENTS

Student's Name	Grade	Date

To self medicate, the student must be able to: (check all that apply)

_____ 1. Respond to and visually recognize his/her name.

_____ 2. Identify his/her medication.

_____ 3. Demonstrate the proper technique for self-administering his/her medication.

_____ 4. Sign his/her medication sheet to acknowledge having taken the medication.

_____ 5. Demonstrate a cooperative attitude in all aspects of self-administration of medication.

Name of Medication	Dosage	Frequency

The above named student has demonstrated the ability to self-administer the physician-prescribed asthma medication, as indicated by the criteria listed above.

Date	Signature (Certified School Nurse)

As the parent/guardian of above named student, I relieve the school district and its employees of any responsibility for the benefits or consequences of the above listed medication when it is physician-prescribed and parent/guardian authorized. I further acknowledge that the school bears no responsibility for ensuring that the medication is taken. I am aware that any improper use/ sharing of the above named medication will result in the immediate confiscation of the inhaler and loss of privilege to self-administer if the medication policy is violated.

Date	Parent/Guardian Signature

I agree to be solely responsible for my asthma inhaler and to follow the directions for its use as ordered by my physician, as well as the district's medication policy. I am aware that any abuse of this privilege will result in the confiscation of my inhaler.

Date	Student's Signature