SCHOOL MEDICATION PERMIT

The administration of medication during school hours is governed by Lakota Board Policy 5330. The use of medication during school hours is discouraged. Use this form only if it is essential that a student receive medication during the school day.

This section is to be completed by the parent or guardian.

Name of Student: ____ Birthdate: ________________

Student's Address: ____

School: ______________________________________ Grade: ________________ Homeroom: ___________

I request school personnel administer the medication as instructed and agree to deliver the medication to the school in the original container and notify the school in the event of a change in physician or medication. It is the student's responsibility to report on time for this medication. I understand that if the physician orders an asthma inhaler for self-administration that I should provide a second inhaler to be stored in the student clinic (in the event the student forgets his/hers) and that the student should report use of the inhaler to the nurse for assessment of effectiveness. **I agree to hold Lakota Local School District and its employees free from all responsibility for the administration of medication.**

Parent/Guardian Signature: ____ Date: ___________________

Phone during school hours: ______________________________________ Other phone: ________________

This section is to be completed by the physician.

Medication: ___________________________________ Date of authorization: ______________________________

Dosage:________________________________ Time(s) to be given: _____________________________________

Date to begin: _______________________________________ Date to end: ___________________________________

Adverse reactions to be reported: ____

Special Instructions - Administration: _____________________________________ Storage: _________________

Other: ____

If the student is to carry an asthma inhaler for self-administration, complete this section:

Procedure to follow if asthma symptoms are not relieved: ____

Adverse reaction if used by unauthorized person: ____

The student has been instructed in the proper use of the inhaler, the expected results and possible side effects, and is capable of carrying and self-administering the medication.

Name of physician (print): _____________________________ Physician's signature: ________________________

Physician address: ____

Physician emergency phone: ___________________________________ Other phone: ________________________

This section for school use only.

The following personnel have read this form and are authorized to administer the medication as outlined:

Signature: ____ Date: ____________________

Signature: ____ Date: ____________________

Signature: ____ Date: ____________________