



PERMISSION TO ADMINISTER MEDICATION

This form covers one (1) student and one (1) medication.

Student Name: _____ **DOB:** _____

Name of Medication: _____

Strength of individual dose: _____ **Dose to be given:** _____
(#mg and/or # pills or tsp): _____

Physical description of form of medication: _____

Time(s) to be administered:
 at _____ am/pm Every _____ hours As needed for _____

Special storage requirements: _____

Possible side effects: _____

Anticipated number of days medication will be given at school:
 For episodic/emergency events only Until end of school year _____ weeks _____ days

**For episodic/emergency medication, a detailed response protocol must be attached

Prescribing Physician's Name: _____

Prescribing Physician's Phone #: _____ Fax: _____

I hereby certify that it is necessary for the above named student to be given medication listed above during the school day, including when he/she is away from school property. I understand such medication may be administered by a non-medically trained staff member to be designated by the Head of School. I give permission for the designated school personnel or administrator to contact the health care provider named above or the pharmacist who filled the prescription to discuss this medication and my student's health. I give permission for the healthcare provider named above, the pharmacist, and/or their designated employees to provide information about this medication and my student's health to the designated school personnel or administrator. I will not hold the school or school personnel liable for any adverse drug reactions when the medication is administered according to the prescribed methods. I will notify in writing the school if my student's medications change. I agree to abide by the rules about medications as outlined in the "Parent/Guardian Responsibilities for Medication" which accompanies this form.

Parent Signature: _____ **Date:** _____

*****FOR SELF-ADMINISTRATION ONLY*****

Pursuant to KRS 158.832 through KRS 158.836, the school permits a student to possess and self-administer asthma, anaphylaxis or diabetes 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 by parent or prescribing physician on self-administration of this medication (for asthmatic, diabetic, or severe allergic reaction ONLY)

No Yes, but supervision by staff required Yes, and supervision by staff not required

Student may carry this medication on their person at all times: No Yes

Physician or Authorized Provider Name (Printed): _____

Physician or Authorized Provider Signature: _____

In accordance with Kentucky State Law, I understand and agree that Summit Academy accepts no liability from an injury sustained by a student from self-administration of medication.

Parent Signature: _____ **Date:** _____

For OFFICE use only

IN/OUT _____
DATE QTY STAFF INITIALS PARENT/GUARDIAN INITIALS

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Parent/Guardian Responsibilities for Medication

Please retain this page for your records.

The parent/guardian is responsible for:

1. Administering the first dosage of any new medication at home. Initial dose of medication that a student has never taken before will not be given during school hours due to the possibility of an allergic reaction.
2. Completing an authorization form for each medicine to be given at school. **Notes from home are not accepted as permission to give medicine at school.** A parent/guardian authorization form must also be completed for over the counter (OTC) medications. **Any OTC medicine must be in the original, unopened container.**
3. Completing authorization section for medication to be self administered by student - **applies only to medications for diabetes, asthma, and anaphylaxis.**
4. Delivering all medicines, including refills, to the designated school personnel in the original pharmacy dispensed container. **For the student's safety and security - DO NOT send medicine to school with your student.**
5. Ensuring that all medicine in its original pharmacy dispensed container with the pharmacy label stating the student's name, drug, dose, and instructions. A pharmacist can provide an additional prescription bottle for school.
6. Keeping a supply of medicine at the school for student administration.
7. Providing any special equipment or materials for giving medicine (i.e., syringes, measuring spoons, applesauce, etc.)
8. Notifying the school of any changes in the medicine, by taking a physician's order or a new prescription bottle at the school and completing a new authorization form.
9. Picking up medicine from the school at the end of the school year and any time it needs to be taken home. **Medicine will not be given to students to take home.**
10. Notifying the school in writing if the medicine is stopped or changed in any way.