



PERMISSION TO ADMINISTER MEDICATION

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

Student Name: _____

DOB: _____

Name of Medication:	Strength of individual dose:
Physical Description or Form of Medication:	Dose to be given (# mg and/or # pills or tsp):
Time(s) to be administered: <input type="checkbox"/> at _____ am/pm <input type="checkbox"/> Every _____ Hours <input type="checkbox"/> As needed for _____	
Special Storage Requirements:	
Possible Side Effects:	
Anticipated number of days medication will be given at school: <input type="checkbox"/> End of School Year <input type="checkbox"/> _____ Weeks <input type="checkbox"/> _____ Days <input type="checkbox"/> For episodic/emergency events only	

Prescribing Physician's Name: _____

Prescribing Physician's Phone #: _____ Fax #: _____

*** 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 on self-administration of this medication (for asthmatic, diabetic, or severe allergic reaction ONLY)

No Supervision Required Supervision 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 any injury sustained by a student from self-administration of medication.

Parent Signature _____ Date _____

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 child's health. I give permission for the health care provider named above, the pharmacist, and/or their designated employees to provide information about this medication and my child'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 the school if my child's medications change. I agree to abide by the rules about medications as outlined in the "Parent/Guardian Responsibilities for Medication" which accompany this form.

Parent Signature _____ Date _____

For Office Use Only

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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 doses of medication that a child 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 authorization form must also be completed for (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 child.**
5. Ensuring that all medicine is in its original pharmacy dispensed container with the pharmacy label stating the child'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 for giving the medicine (i.e., syringes, measuring spoon, etc.)
8. Notifying the school of any changes in the medicine, by taking a physician's order or a new prescription bottle to 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 your child to take home.**
10. Notifying the school in writing if the medicine is stopped or changed in any way.