PORTLAND CHRISTIAN SCHOOL SYSTEM

Permission Form for Prescribed Medication

Student Name: _____ Student Age: _____

Date of Birth: _____ Grade: _____

TO BE COMPLETED BY PHYSICIAN OR AUTHORIZED PROVIDER

Name of medication: _____

Reason for medication: _____

Form of medication/treatment: ☐ Tablet/capsule ☐ Liquid ☐ Inhaler ☐ Injection ☐ Nebulizer ☐ Other_____

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

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: _____

Physician's Signature _____Physician's Name: _____

Date: _____Phone:_____Address:_____

For Self-Administration ONLY*For Self-Administration ONLY***For Self-Administration ONLY**

***Pursuant to KRS 158.832 to KRS 158.836 _____school permits a student to possess and self-administer asthma, diabetic, or anaphylaxis medication at school and at school related functions upon completion of the appropriate sections of this form by the parent/guardian and the student's physician.

This student has been trained on self-administration of this medication: to be completed for asthmatic, diabetic or severe allergy ONLY

☐ No ☐ Supervision required ☐ Supervision not required

This student may carry this medication: ☐ No ☐ Yes

Please indicate if you have provided additional information:
☐ On the back side of this form ☐ As an attachment

Physician's Signature: _____ Date: _____

Parental Consent

I am the parent/guardian of _____; I give my permission for him/her to take the following medication (see below) for use during the school day. I hereby release the school and its employees from any claims or liability connected with its reliance on this permission and agree to indemnify, defend and hold them harmless from any claims or liability connected with such reliance.

_____
Name of Parent/Guardian (please print)

_____ _____ _____
Parent/Guardian Signature Daytime Phone Date

TO BE COMPLETED BY SCHOOL PERSONNEL

School: _____ School Year: _____ Date form received: _____

I/we acknowledge receipt of this Physician's Statement and Parent Consent. _____