Warren County Schools
School Health Services

Medication Permission Form

STUDENT *Date of Birth*				Parent Legal Guardian
	YEAR		Bus Car	Cell Phone Work Phone Home Phone
Teacher				
Grade _____				

Name of Medication	___ mg per tablet ___ mg per teaspoon/5ml	take _____ tablet(s) take _____ teaspoons take _____ puffs	Total______ mg per dose	**TIME TO TAKE** ___ after lunch ___ as needed ___ before PE/recess

Reason for Medication __ADHD __Headache/Migraine __Fever/Pain __Asthma __Allergy

Side Effects / Precautions ____

START DATE ____/_____/_____ STOP DATE ____ / ____ / ____

☐ **Supervised Administration: School Staff will keep and give this medication for this student.**

☐ **Self-Administered Emergency Medication: Student is capable to keep/take this medication on his/her own.**

SELF CARRIED MEDICATIONS: INSULIN, GLUCAGON, EPI-PEN AND INHALERS ONLY

Parent Signature for self administration.________________________________ Parent to bring extra for med box.

- Healthcare Provider *Signature*____
- Healthcare Provider (PRINT)_________________________Date___________Phone___________

TO BE COMPLETED BY PARENT / LEGAL GUARDIAN

I hereby give my permission for my child (named above) to receive medication during school hours. I understand that the school undertakes no responsibility for the administering of the medication, and this medication must be prescribed by the licensed physician. I hereby release the school board and its agents and employees from any and all liability that may result from my child taking the prescribed medication. I also authorize my child's medical care provider to release information to the school nurse that is deemed necessary for the administration of medication at school in accordance with the Health Insurance Portability and Accountability Act of 1996
(HIPPA). I agree to provide and maintain an emergency phone contact. This consent is good for the school year, unless revoked.

- ***Parent/Legal Guardian Signature*****____*Date* __________**

DAYTIME PHONE NUMBERS ____

Teachers Receiving Copies(Include Date)____

☐ Student demonstrates adequate knowledge to keep, carry and take this medication.
School Nurse ___________________ Date________________

BUS DRIVER NOTIFIED ___________ BUS NUMBER____________