Permission Form for Prescribed Medication
Individual Health Plan

School: _ Select School _Date form received by the School: _____

Student's Name: _____ Grade: _____ Homeroom/Classroom: _____

Student's Age: _____ Date of Birth: _____

TO BE COMPLETED BY THE PHYSICIAN OR HEALTH CARE PROVIDER AS RELEVENT TO THE PRESCRIPTION MEDICATION

Diagnosis: _____

Characteristics/history of health condition: _____

Current health status or goal: _____

Name of medication: _____ Reason for medication: _____

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

Describe schedule and dose to be given at school: _____

Starting Date: ☐ date form received ☐ other, as specified: _____

Stopping Date: ☐ for episodic/emergency events only ☐ end of school year ☐ other date/duration: _____

Restrictions and/or important effects: ☐ Yes. Please describe: _____

Special storage requirements: ☐ None ☐ Refrigerate ☐ Other _____

Student is capable of/responsible for self-administering this medication: ☐No ☐Yes ☐Supervised ☐Unsupervised

Student has been instructed in self-administering the medication: ☐No ☐Yes

Student must carry this medication on his/her person: ☐No ☐Yes

Student is authorized to transport the medication on the bus: ☐ No ☐ Yes

Please indicate additional information: ☐ On the backside of this form ☐ As an attachment

_____ _____
Physician/Health Care Provider Signature ***Date***

_____ _____
Signature of Parent/Guardian ***Date***

Name of Physician/Health Care Provider: _____

Address: _____

Phone #: _____ Fax #: _____

NOTE: **PLEASE REPORT CONCERNS ABOUT MEDICATIONS OR THE STUDENT'S CONDITION TO THE ABOVE PHYSICIAN/HEALTH CARE PROVIDER. IN THE EVENT THE PRINCIPAL/DESIGNEE IS NOTIFIED OF THE POSSIBILITY OF AN ADVERSE OR EXTREME REACTION TO A MEDICATION, S/HE SHALL INFORM THE STUDENT'S TEACHER(S) OF SUCH POSSIBILITY BEFORE THE STUDENT BEGINS THE MEDICATION SCHEDULE.**

Permission Form for Prescribed Medication Individual Health Plan

TO BE COMPLETED BY PARENT/GUARDIAN FOR ALL MEDICATIONS

As the parent or legal guardian of the student named below, I authorize my child to take the following medication as noted:

Name of Medication: _____ Dosage/Schedule: _____

Other Information: _____

I give permission for _____ to receive the above medication(s) at school according
Student's Name
to standard school policy and expressly hold harmless, and waive any liability on behalf of, the school or its employees and agents concerning any injuries or reactions resulting from administration of the above medication unless such is the result of negligence or misconduct on behalf of the school or its employees. For on-going medications, I understand that I have the ultimate responsibility for providing the school with an adequate supply of medication to enable orders from a physician or health care provider to be followed.

Date: _____ *Signature:* _____ *Relationship:* _____

Home Phone: _____ *Work Phone* _____ *Emergency Phone* _____

Signature of parent/guardian on this form allows school nurse to contact student's physician for relevant medical information.

TO BE COMPLETED BY SCHOOL PERSONNEL

I/we acknowledge receipt of the foregoing statement and authorization.

Administrator/designee _____ Date _____

NOTIFICATION TO SCHOOL PERSONNEL FOR GENERAL EMERGENCY PLAN OR ACTION

Refer to instruction sheets and/or separate MD orders or individualized health plans for emergency medication administration (addressing seizures, asthma, anaphylactic reactions, and diabetes). Notify school nurse/designee upon receipt of this form. School nurse/designee to identify plan of care/outcome (if applicable).

Plan of care/outcome: _____

*If student begins to have severe shortness of breath and/or color becomes pale, cyanotic (bluish), or ashen: Call EMS (911).
*If breathing stops: CPR certified staff should initiate rescue breathing and CPR if necessary. Obtain AED.
*Contact parent/guardian or emergency contact immediately.
*Administer emergency medication as ordered (if applicable), and notify EMS of administration of this medication.
*If student begins to have a seizure or seizure like activity, with no prior history of seizures, call EMS (911).
*If student begins to have a seizure or seizure like activity, with known history of seizures, follow MD orders.
*If student begins to have a seizure with progressive respiratory distress, or has another seizure right after the first, call EMS (911).

Permission Form for Over-the-Counter Medication

Student's Name: _____ Grade: ___ Homeroom/Classroom:_____

Student's Age: ____ Date of Birth: _____ School: _ Select One _

The school nurse's office offers over the counter medications for the students with parent/guardian permission.

Please indicate below the medications you permit to be administered to your child.

This form will keep us from having to call you each time your child needs something different related to occasional basic medical needs. It will also help us get your child back to class quickly. Thank you for allowing us to care for your child.

☐ **Acetaminophen (*Regular Strength*)**	☐ **Antibiotic ointment**	☐ **Eye drops**	☐ **Muscle/joint pain relief (*gel/cream*)**
☐ **Acetaminophen (*Extra Strength*)**	☐ **Antifungal cream**	☐ **Ibuprofen**	☐ **Oral tooth/gum medication**
☐ **Allergy Relief**	☐ **Antihistamine tablet**	☐ **Insect bite/sting relief**	☐ **Throat spray/lozenge**
☐ **Antacid**	☐ **Anti-itch cream**	☐ **Medicated lip ointment**	☐ **Analgesic spray/lotion**
☐ **Anti-nausea**	☐ **Menstrual pain reliever**	☐ **Calamine lotion**	☐ **Hemostatic agent**

☐ **None of the above**

- I authorize the nursing and medically trained staff at Hart County Schools and/or contracted services to provide over the counter medication as noted above and as needed to my child.
- I understand that it is my responsibility to directly notify the nursing staff in writing at the school where my child is enrolled of any changes in my child's OTC medication needs.
- I understand that in the event of an adverse reaction any OTC medication, the medication will be halted, and I will be notified by the nursing staff at the school.
- I understand that this permission form will be kept on file in my child's student health record and will not be changed without written notification.
- I understand that this document's confidentiality is governed by FERPA (Family Education Rights to Privacy Act) and that all rules under such Act will be followed by all parties.
- I understand that a generic equivalent may be administered to my child.
- I expressly hold harmless, and waive any liability on behalf of, the school or its employees and agents concerning any injuries or reactions resulting from administration or lack of administrative of the above medication.
- I understand that I must provide to the school nursing staff a signed physician's order/statement in order to exceed the recommended dosage guidelines (as printed on the bottle/packaging) when administering the indicated medications.

Permission Form for Over-the-Counter Medication

Notification of Allergies

I understand that it is my sole responsibility to notify the school nursing staff of any allergies or possible complications related to over-the-counter medications. Listed below are all known allergies or potential complications:

_____
_____
_____
_____
_____

_____ _____
Parent/Guardian Signature *Date*

TO BE COMPLETED BY SCHOOL PERSONNEL

I/we acknowledge receipt of the foregoing statement and authorization.

_____ _____
Administrator/Designee *Date*

Review/Revised:10/17/2019