Student Name_____ Date of Birth_____

School_____ Homeroom Teacher_____ Grade_____

Parent Name and phone number: _____

This section to be completed by physician/licensed medical provider only

ONLY ONE MEDICATION PER FORM

Medication (include generic name):_____

Dose: _____ Route: _____ Time(s) to be given at School: _____

Frequency: _____

Relationship to meals: _____

Purpose of medication (Related diagnosis): _____

Possible Side effects: _____

Some medications may be self-administered at school and/or on a field trip. If appropriate, I consider this student to have the maturity and knowledge to self-administer his/her medication. Yes___ No___

Physician Signature: _____ Date: _____

Office Phone Number: _____ Practice Stamp

This section to be completed by parent/guardian:

PARENT'S PERMISSION I hereby give my permission for my child (named above) to receive medication during school hours administered by the school nurse or trained school personnel. All medications, including over-the-counter products, have been prescribed by a licensed health care provider. Medications will be furnished in current pharmacy-labeled bottles with identifying information and brought to school by parent/guardian. I assume full responsibility for informing the school of any change in my child's health and/or medication. I agree that medication dosage cannot be changed without a physician's order. Further, I hereby release the KIPPNC Public School and their agents and employees from all liability that may result from my child taking the prescribed medication. I understand that I am expected to pick up any remaining medication at the end of the school year or end of dosage period or the medication will be discarded 7 days thereafter.

I give consent for the school nurse or trained personnel to exchange information with the medical prescriber about medicine administration, dose clarification, response to medication, adverse effects, etc.

_____**Initial**

Please complete the back.

NOTE: I understand some emergency medications may be self-carried and administered. Additionally, scheduled medication may be self-administered under supervision while traveling on a field trip. If appropriate, I consider my student to have the maturity and knowledge to self-administer his/her medication and understand that the school system can assume no liability for monitoring the self-administration. I assume the responsibility for ensuring that my child is carrying and taking their medication as ordered. Prior to acceptance of a self-administered medication on campus, the school nurse must ascertain the student's maturity and knowledge, as well as review/ensure compliance with KIPPNC Public School protocol. Schools may revoke this privilege if the student proves to be irresponsible or incapable. With these facts in mind, I give permission for my child to self-administer medication:

Yes___ No___

Parent/guardian signature: _____ Date: _____

This section to be completed by school staff

Form Received on _____ School Year: _____

Reviewed by School Nurse or Trained personnel: _____

Medication received at school: _____