

Permission Form for Prescribed Medication

TO BE COMPLETED BY SCHOOL PERSONNEL

School: Beth Yeshurun Day School School Year: _____ Date form received: _____
 I/we acknowledge receipt of this Physician's Statement and Parent Authorization. _____

Student Name: _____ Student age: _____ Date of Birth: _____
 Grade: _____ Homeroom/Classroom: _____

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◆◆◆For Self-Administration ONLY◆◆◆

Pursuant to KRS 158.832 to KRS 158.836 _____ school permits a student to possess and self-administer asthma or anaphylaxis 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: **to be completed for asthmatic, diabetic or severe allergic reaction (anaphylaxis) 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

Signature: _____ Date _____
Physician or Authorized Provider

TO BE COMPLETED BY PARENT / GUARDIAN

I give permission for (name of child) _____ is to receive the above stated medication at school according to standard school policy. I release the **Beth Yeshurun** School Board and its employees from any claims or liability connected with its reliance on this permission. (Parent/guardians to bring the medication in its original container.)

Date: _____ Signature: _____ Relationship: _____
 Home phone: _____ Work phone: _____ Emergency phone: _____