JESSAMINE COUNTY SCHOOLS
AUTHORIZATION TO ADMINISTER MEDICATION FORM

For Use by School Only:

Date Received:____________________

Name of School: ____

Student Name: ______________________________________ D.O.B: ________________________

Grade: ______________________________ Teacher: ____________________________________

To Be Completed by Parent/Guardian

Date: ___________________________________

I hereby request school personnel of ________________________________ Public Schools to give medication to my child: ____. This medicine has been prescribed for my child by Dr. ____________________________________, whose address is and phone number is ____. I understand that this medication will be administered according to school policy. I expressly waive any liability on behalf of the school as a result of administration of this medication.

Parents Telephone No: Home____________________________ Work ___________________

Cell: _________________________________ Emergency ____________________________

RELEASE OF INFORMATION: *I give permission for the school nurse to review or discuss any information with the physician regarding this medication or health condition related to this medication. Any and all medical information will be held in strict confidence.*

Signature of Parent/Guardian: ____

Student Name: ___________________________________ D.O.B. _____________________

School: ____

Student Name: ______________________________ D.O.B. _______________ School: _________

To be completed by the physician or authorized prescriber:

1. Name of Medication: ____
2. Dosage: ____
3. Time of Day: ____
4. Reason for Medication: ____
5. Form of Medication: ____

☐ Tablet/Capsule ☐ Liquid ☐ Injection

☐ Inhalant ☐ Nebulizer ☐ Other

☐ If inhaler, patient has been trained in the proper use of the inhaler.

☐ For Episode or Emergency Only.

6. Instructions: (Please use terminology that non-medical personnel can understand.)

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7. Reactions or side effects: Please list any potential reactions the child might have:

____

8. Does medication need to be refrigerated? _________________________________

This student is capable of self administering this medication:

☐ No ☐ Yes

This student needs to carry this medication at all times during school hours:

☐ No ☐ Yes

Date: _________________ Physician Signature: _______________________________________