LAKOTA LOCAL SCHOOLS

SCHOOL MEDICATION PERMIT

The administration of medication during school hours is governed by Lakota Board Policy 5330. The use of medication during school hours is discouraged. Use this form only if it is essential that a student receive medication during the school day.

This section is to be completed by the parent or guardian.

Name of Student: _____ Birthdate: _____

Student's Address: _____

School: _____ Grade: _____ Homeroom: _____

I request school personnel administer the medication as instructed and agree to deliver the medication to the school in the original container and notify the school in the event of a change in physician or medication. It is the student's responsibility to report on time for this medication. I understand that if the physician orders an asthma inhaler for self-administration that I should provide a second inhaler to be stored in the student clinic (in the event the student forgets his/hers) and that the student should report use of the inhaler to the nurse for assessment of effectiveness. **I agree to hold Lakota Local School District and its employees free from all responsibility for the administration of medication.**

Parent/Guardian Signature: _____ Date: _____

Phone during school hours: _____ Other phone: _____

This section is to be completed by the physician.

Medication: _____ Date of authorization: _____

Dosage: _____ Time(s) to be given: _____

Date to begin: _____ Date to end: _____

Adverse reactions to be reported: _____

Special Instructions - Administration: _____ Storage: _____

Other: _____

If the student is to carry an asthma inhaler for self-administration, complete this section:

Procedure to follow if asthma symptoms are not relieved: _____

Adverse reaction if used by unauthorized person: _____

The student has been instructed in the proper use of the inhaler, the expected results and possible side effects, and is capable of carrying and self-administering the medication.

Name of physician (print): _____ Physician's signature: _____

Physician address: _____

Physician emergency phone: _____ Other phone: _____

This section for school use only.

The following personnel have read this form and are authorized to administer the medication as outlined:

Signature: _____ Date: _____

Signature: _____ Date: _____

Signature: _____ Date: _____