WHITEFIELD ACADEMY

PRESCRIPTION AND OVER-THE-COUNTER MEDICATION REQUEST FORM

PARENTS PLEASE READ ALL INFORMATION BELOW BEFORE SIGNING.

Only medication(s) that are medically necessary during school hours for a student's attendance or a written IHP (individual health plan) should be sent to school.
Persons who may assist your child with medication(s) include the School Health Coordinator or trained personnel..
*The medication(s) **MUST** be received in the original **unopened container** and properly labeled with student's first and last name. Prescription medications **MUST** be in their original pharmacy container with the child's name and the prescribing doctor's directions.*
NOTE: The very first dose of a prescribed medication for a condition or illness cannot be given at school. School personnel are not responsible for any ill effects which might occur from this medication.
OVER-THE-COUNTER MEDICATIONS NEEDED LONGER THAN TWO WEEKS FROM THE SCHOOL MAY REQUIRE A PHYSICIAN'S WRITTEN ORDER.

PLEASE FILL OUT ALL INFORMATION IN ORDER FOR MEDICATION TO BE DISPENSED.
One child and one medication per form. Parent/guardian **MUST** complete and sign form.

NAME OF STUDENT: _____D.O.B_____

DATE: _____ TEACHER: _____GRADE: _____

NAME OF MEDICATION: _____

DOSAGE: (amount): _____

TIME TO BE GIVEN AT SCHOOL: _____

HOW IS MEDICATION TO BE GIVEN: _____
(Example: by mouth, by inhaler, with food or after meals)

REASON FOR DISPENSING MEDICATION: _____

WHEN WAS THE FIRST DOSE OF MEDICATION GIVEN? _____

ANY ALLERGIC REACTIONS TO THIS MEDICATION? _____

_____ _____
PARENT/GUARDIAN SIGNATURE DAYTIME PHONE NUMBER

_____ _____
PHYSICIAN'S NAME PHYSICIAN'S PHONE NUMBER

Reviewed and authorized by SHC_____ Staff_____ may/may not administer_____

SHCSignature_____

ONLY STUDENTS WHO ARE ALLOWED TO SELF MEDICATE FOR SPECIAL HEALTH CARE NEEDS PLEASE SEE BACK SIDE

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*****THIS SIDE FOR SELF-ADMINISTERING MEDICATIONS ONLY*****

Pursuant to KRS 158.832 to KRS 158.36 Whitefield Academy School permits a student to possess and self-administer asthma, anaphylactic medications and enzyme tablets 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 the medication:

_____No _____Supervision required _____Supervision not required

This student may carry this medication: _____No _____Yes

Signature: _____Date: _____
Physician or Authorized Provider

I give permission for _____to receive the stated medication on the front page at school according to school policy. I release Whitefield Academy, School Health Coordinator and its employees from any claims or liability connected with its reliance on the permission.
(Parent/guardians are to bring the medication in its original container/package.)

Date: _____ Signature: _____Relationship: _____

Home phone: _____ Work phone: _____Emergency phone: _____