**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 THE INFORMATION FOR MEDICATION TO BE DISPENSED FOR THE CURRENT SCHOOL YEAR.**

 **MEDICATIONS ARE TO BE PICKED UP BY PARENT BY THE LAST DAY OF SCHOOL.**

**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**\*\*\*

 **\*\*\*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: \_\_\_\_\_\_\_\_\_\_\_\_\_