**School Year:** **School** :

**PARENTAL CONSENT AND LICENSED PRESCRIBER AUTHORIZATION**

**FOR ADMINISTERING MEDICATION**
**(Use a separate authorization form for each medication)**

Student Name: _____ _____ _____
(Last Name) (First Name) (M.I.)

Grade: _____ Date Of Birth: _____/_____/_____

Allergies:_____

**Parental Consent**

I am the parent or guardian of _____. I give my permission for him/her to take the following prescribed medication while in Patrick County Public Schools. I hereby acknowledge that I have read and I understand the School Board Regulations relating to the taking of medications. I hereby release Patrick County Public Schools and its employees from any claims or liability connected with such reliance on this permission and agree to indemnify, defend and hold them harmless from any claim or liability connected with such reliance. I authorize a representative of the school to share information regarding this medication with the above licensed prescriber.

**Signature:_____ Date:_____**

**Medication Authorization**
(For Use By Licensed Prescriber ONLY)

Relevant Diagnosis:_____ Medication:_____

Dates Medication Must Be Administered At School:
_____ Short Term
_____Every day at school
_____ Episodic/Emergency Events ONLY

Dosage (Amount) _____ Route _____ Form _____ Time(s) of Day _____

A. Serious reactions can occur if the medications not given as prescribed: ____YES____NO
If yes, describe: _____

B. Serious reactions/adverse side effects from this medication may occur: ____YES____NO
If yes, describe:_____

Action/Treatment for reactions:_____

Report to you: _____YES _____NO (Drug information sheet may be attached)

Special Handling Instructions: _____Refrigeration _____Keep out of sunlight _____Other (Describe)

**Licensed Prescriber's Signature:_____ Date:_____**

**Asthmatic/Diabetic Only**
This student is both capable and responsible for self-administering this medication:
_____NO _____YES – Supervised _____YES – Unsupervised
I recommend that this student carry this medication for the following reason(s):
_____Asthmatic _____Diabetic _____Other

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**Licensed Prescriber's Name:_____**
**(Please Print)**
**Telephone Number: ( )_____-_____ Emergency No. ( )_____-_____**

**Licensed Prescriber's Signature:_____ Date:_____**