Decorah Schools Health Service

PERMISSION FOR MEDICATION

Student Name_____ Grade_____

Late start days: Please give AM medications at school YES NO

1) Name of medication_____Dosage_____

Time to be given_____ Begin_____End_____

2) Name of medication_____Dosage_____

Time to be given_____ Begin_____End_____

3) Name of medication_____Dosage_____

Time to be given_____ Begin_____End_____

Inhalers: Student has permission to carry and self-administer _____(parent initial)

Epi-Pen: Student has permission to carry and self-administer _____(parent initial)

Insulin/Glucagon: Student has permission to carry and self-administer _____
(parent initial)

I request and authorize school personnel to administer the above medication to my child. I agree that we (parent/guardian) will not hold liable any member of the school staff who is directed by us to assist our child in taking the listed medication.

I understand that all (prescription and non-prescription) medication **must be in the original container.** If the medication is a prescription medication the pharmacy label must show the student's name, the date prescribed, the name of the medication, the dosage, times and method for administration, the prescribing physician, and any special storage required.

I agree to provide a supply over the counter medication if I have requested that it be given.

Students in Grade 6-12 may elect to carry a one-day supply with this signed permission.

Signature of Parent/Guardian_____

Date_____

(Rev. 4/2017)