Scott County District
Over-the-Counter Medication
Permission Form

Parent to Complete

Date:_____

Name of Student:_____ Date of Birth:_____

Teacher:_____ Grade:_____

Name of Medication:_____ Dosage:_____

- **Dosage shall not exceed the recommended amount or frequency as per labeling information.**

Time to be given at school:_____

Reason or health problem:_____

Date first dose was given:_____ Date last dose is to be given:_____

How is it to be taken:_____
(example: by mouth, by inhaler, with food or after meals)

When was first dose of this medication given?_____

- **First does of any medication must be given by the parent/guardian.**

To be completed by parent/guardian:

I give permission for (name of child)_____ to receive the above medication at school according to standard school policy. **(All medications brought into school shall be in the original container, labeled with child's first and last name).**

Signing this form shall release Scott County School System and staff members from any liability of any nature that might result from the administration of medication to the student.

Date:_____ Signature of parent/guardian:_____

Home No:_____ Work No:_____

Emergency No:_____ Cell No:_____

Signature Box/Initial

_____	____
_____	____

SCOTT COUNTY DISTRICT
MEDICATION LOG SHEET
Month_____ Year _____

One medication sheet per prescription

Student Name:_____ DOB_____

Date:_____ Medication Received_____ Initial Quantity_____

Staff Initial _____ Parent/Guardian Signature:_____

MEDICATION:	DOSAGE:	TIME (S) TO BE GIVEN:

Date first dose was given:_____ Date last dose is to be given:_____

Doctor:_____Pharmacy:_____

Medication being given for:_____

Side effect(s) comments:_____

Date	Time	Staff Initial	Quantity Remaining	Comments or Problems	Student Initial Middle/High School

Any person giving medication for any reason must sign signature box located at the top of this page. Medication documentation must reflect missed dosages, absences, and medication returned to parents. Medication returned to parents reflects quantity returned with signatures from parents & staff releasing medication, (please fill out lines below).

Date:_____ Medication Released_____ Quantity Released_____

Personnel Releasing Medication_____ Parent/Guardian/Student_____

SCOTT COUNTY SCHOOL DISTRICT
PERMISSION FORM FOR PRESCRIBED MEDICATION, INCLUDING ASTHMA

(To be filled out by school personnel)

School_____ Date form received:_____

Student: _____ Date of Birth: _____

Grade: _____ Teacher/Classroom: _____

To be completed by the physician or authorized prescriber:

Name of medication: _____
Prescribed dosage: _____
Time of day for dosage: _____
Reason for medication: _____

Form of medication/treatment:
☐ Tablet/capsule ☐ Liquid ☐ Inhaler ☐ Injection ☐ Nebulizer ☐ Other _____

Possible reactions or side effects of medicine: _____
_____

Known drug allergies_____

Start and stop dates: From _____ To _____ (limit of one school year)

Restrictions: ☐ None anticipated ☐ Yes
Please describe _____
_____

Special storage requirements: ☐ None ☐ Refrigerate Other:_____

Student has asthma and has been instructed in self-administration of asthma medications. _____ Yes _____ No

This student is both capable and responsible for self-administering this asthma inhaler: ☐ No ☐ Yes-Supervised ☐ Yes-Unsupervised

Please indicate if you have provided additional information: ☐ On the back side of this form ☐ As an attachment

Date: _____ **(Dr.) Signature:** _____

Physician's Name: _____ **Phone Number:** _____
(Please Print)

Address: _____

To the school: Please report concerns about medications or disease to the above physician.

To be completed by parent/guardian:

I give permission for (*name of child*) _____ to receive the above medication at school according to standard school policy. (All prescription medications brought into school shall be in original container, with pharmacy label attached).

Signing this form shall release the Scott County School System and staff members from any liability of any nature that might result from the administration of medication to the student including self-administered asthma medications.

Date: _____ Signature of parent/guardian: _____

Phone No: Home _____ Work _____ Emergency _____ Cell _____