

SHELBYVILLE CENTRAL SCHOOLS HEALTH SERVICES

Physician Permission for Medication and Parent/Guardian Consent

The Shelbyville Central School District recognizes that to insure good health and best educational conditions, it is sometimes necessary for students to receive medication during school hours. Whenever possible, medications should be given to students at home, before or after school. If medication is to be given during school hours, the following procedures must be used:

- All medication must be in its original container. All prescription medication must be labeled with student name, name of medication, dose and frequency of medication. Medication must not be expired. **Please do not send unlabeled containers or medications to school.**
- All medications must be accompanied by this completed and signed permission slip from parent or guardian. All prescription medications that are to be given four (4) weeks or longer must have physician signature.
- K-8 students are not permitted to transport medication to school. Grades 9-12 may transport medication to school with parental permission, but it must be delivered to the health clinic immediately upon arrival.
- Students are expected to come to the health clinic at the appropriate time to take their medication. Students who need to self-administer medications (ie: inhalers) are permitted to do so with written permission by a parent/guardian and physician. Students are required to report each self-administered dose to the school nurse when taken during regular school hours.

If you have any questions regarding medication administration, please phone your child's school health clinic.

I grant permission for the school nurse, health assistant, or any person authorized by the school, to administer the medication listed below. If a medical necessity arises, the school nurse/health assistant may contact the prescribing professional to discuss this medication.

Student Name _____ Grade _____ D.O.B. _____

Diagnosis _____ Allergies _____

Medication _____ Dose _____ Route _____ Frequency _____

Time to Administer at School _____ Start Date _____ Duration of order _____

Comments _____

*Physician Name Printed _____ Date _____

*Physician Signature _____ Telephone _____

**Authorization for Self-Administering Medication

As the health care provider for this student, circling yes below verifies that he/she has been taught proper use of his/her medication (inhaler, Epi Pen) that has been prescribed for preventing and/or treating emergencies, has adequate knowledge of the medication, reason it is needed, and is thought to be responsible enough to carry his/her medication and use it properly under the general supervision of school personnel.

_____ Student may self administer inhaler/Epi Pen. Yes ___ No ___
Date _____ Physician Signature _____

Parent/Guardian Consent:

I, the undersigned give permission to the School Nurse/Health Assistant to administer the above named medication to my child. I understand that school personnel are not responsible for any problems arising from the use of this medication, its side effects or for the omission of medication.

I give permission to the School Nurse/Health Assistant to share information relevant to the prescribed medication administration as determined appropriate for my child's health and safety.

Yes _____ No _____

I give permission for a teacher/teaching assistant to administer my child's daily medication while attending a field trip.

Yes _____ No _____

I give permission for my child (grades 9-12) to transport their own medication to and from school with the understanding the medication will be delivered to the school health clinic immediately upon arrival.

Yes _____ No _____

I understand I may retrieve the medication from school at any time; however, the medication will be destroyed if it is not picked up within one week following the termination of the order or the last day of school, whichever occurs first.

Parent/Guardian Signature _____ Telephone _____ Date _____

*Physician signature required if prescription medication to be taken four (4) weeks or greater.

**Physician signature required for student to self administer medication.