

**PARIS INDEPENDENT SCHOOLS - PERMISSION FORM FOR EMERGENCY ONLY PRESCRIBED MEDICATION**

**TO BE COMPLETED BY SCHOOL PERSONNEL**

School: \_\_\_\_\_ School year: \_\_\_\_\_ Date forms received: \_\_\_\_\_

I/we acknowledge receipt of this Physician's statement and Parent Authorization. \_\_\_\_\_

Student Name: \_\_\_\_\_ Student age: \_\_\_\_\_ Date of Birth: \_\_\_\_\_

Grade: \_\_\_\_\_ Homeroom/Classroom: \_\_\_\_\_

**TO BE COMPLETED BY PHYSICIAN OR AUTHORIZED PROVIDER**

Name of medication: \_\_\_\_\_

Reason for medication: \_\_\_\_\_

Form of medication/treatment:

Tablet/capsule     Liquid     Inhaler     Injection     Nebulizer    Other \_\_\_\_\_

**Instructions** (Schedule and dose to be given at school): \_\_\_\_\_

Start:     Date form received     Other, as specified: \_\_\_\_\_

Stop:     End of school year     Other date/duration: \_\_\_\_\_

For episodic/emergency events only

**Restrictions and/or important side effects:**     No restrictions

Yes. Please describe: \_\_\_\_\_

**Special storage requirements:**     None     Refrigerate    Other: \_\_\_\_\_

Physician's Signature \_\_\_\_\_ Physician's Name: \_\_\_\_\_  
Date \_\_\_\_\_ Phone \_\_\_\_\_ Address: \_\_\_\_\_

**••• For Self-Administration ONLY ••• For Self-Administration ONLY ••• For Self-Administration ONLY •••**

*Pursuant to KRS 158.832 to KRS 158.836- Paris Independent Schools permits a student to possess and self-administer asthma or anaphylaxis medication 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 also been instructed on self-administration for this medication: **to be completed for asthmatic, diabetic or severe allergic reaction (anaphylaxis) ONLY**

No     Supervision required     Supervision not required

This student may carry this medication:     No     Yes

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

Signature: \_\_\_\_\_ Date \_\_\_\_\_

**Physician or Authorized Provider**

**TO BE COMPLETED BY PARENT/GUARDIAN**

I give permission for (name of child) \_\_\_\_\_ is to receive the above stated medication at school according to standard school policy. I release Paris School Board and its employees from any claims or liability connected with its reliance of this permission.

(Parent/guardians to bring the medication in its original container.)

Date: \_\_\_\_\_ Signature: \_\_\_\_\_ Relationship: \_\_\_\_\_

Home phone: \_\_\_\_\_ Work phone: \_\_\_\_\_ Emergency phone: \_\_\_\_\_