HAWKINS COUNTY SCHOOLS
HEALTH SERVICES DEPARTMENT
Phone: (423)272-7629
Fax: (423)272-8389

RETURN TO: _____
SCHOOL FAX # SCHOOL NURSE

PERMISSION FOR MEDICATION
(PRESCRIPTION AND NON-PRESCRIPTION)

A responsible adult must bring the medication to the school. Student possession of any form of medication that has not been checked into the principal's office is subject to disciplinary action. Medications should be taken at school only when the student's health requires that they be given during school hours. No medication will be sent home by students.

All medication must be brought to school in the original, unopened container and must be labeled with the student's name.

Students Name _____ DOB _____ Grade _____

School _____ Teacher _____

Reason for Medication _____ Allergies _____

Medication _____ Dosage _____ Time(s) _____

Route (circle): Oral Topical Inhaled Other Start Date _____ Stop Date _____

Possible Side Effects _____

I give permission for school personnel to assist my child in self-administering the above medication. I acknowledge that I have instructed my child in the correct administration of this medication and that my child is competent to self-administer the medication with assistance. I also authorize, as needed, the sharing of information related to my child's health between the school nurse (or designee) and the health care provider listed below.
* In the event of a school schedule change or delay: It is the parent's responsibility to notify the school nurse of any changes to your child's medication schedule.

_____ _____ _____
Parent/Guardian Signature Date Home Phone

Work Phone _____ Mother's Cell _____ Father's Cell _____

Emergency Contact _____ Phone _____

Comments _____

***If over-the-counter medication, stop here.** ***If prescription medication, complete entire form.**
(Prescription medication must be brought to school in the original, pharmacy labeled container.)

Inhaler: Has the student been instructed in self-administration of inhaler? _____

Assessment of student's competency for Self-Possession and Self-Administration of prescribed inhaler medication: _____

Additional Health Care Provider instructions to the above: _____

_____ _____ _____
Print Health Care Provider's Name Phone Number Address

_____ _____
Health Care Provider's Signature Date