SALLIE B. HOWARD SCHOOL OF ARTS & SCIENCE

SUPERVISED and EMERGENCY MEDICATION PERMISSION FORM

Student:	Parent/Guardian:
Today's Date:	Home Phone:
School: Bus:	Work Phone:
Grade: Teacher:	Cell Phone:

USE A SEPARATE FORM FOR EACH MEDICATION.

NOTE: *All administrations of medications must be in compliance with SBH board policies.*
ALL MEDICATIONS ADMINISTERED BY SALLIE B HOWARD MUST BE DELIVERED IN THE ORIGINAL CONTAINER AND BE PROPERTY LABELED WITH THE STUDENT'S NAME, PHYSICIAN'S NAME, DATE OF PRESCRIPTION, NAME OF MEDICATION AND DOSAGE. MEDICATION WILL BE ADMINISTERED TO STUDENTS DURING REGULAR SCHOOL HOURS ONLY. NO MEDICATION WILL BE ADMINISTERED WITHOUT PROPER COMPLETION OF THE MEDICATION DISPENSING FORM.

Failure of the parent/guardian to provide documentation will require the parent/guardian to be present in the school to administer the medication properly.

Name of Medication:	Dosage/mg:	Route: mouth, eyes, nose, etc.	Times medication is to be given at school:

Reason for Medications:_____

Special Instructions:_____

Side/Effects:_____

Effective Dates:
Start Date: _____ to Stop Date: _____

TO BE COMPLETED BY HEALTHCARE PROVIDER:

___ **Supervised Administration:** School nurse will keep all medications contained in the school nurse infirmary and medication will be taken in the presence of SBHS school Nurse or designated person.

___ **SELF_ADMINSTRED EMERGENCY MEDICATIONS:** Student had been instructed and is capable to keep/take this medication on his/her own based on the medical necessity. **This is only designated for EpiPen.**

___ **STUDENT will not share this medication with anyone.**

___ **All medication must be in a properly labeled pharmacy or store container.**

It is my understanding that the employees of Sallie B. Howard School charged with the administration of this treatment during school hours rely solely on directions contained in this document. I further certify that I am the physician who prescribed the treatment and that the student named above is under my supervision as a patient.

<u>*MUST be signed by Healthcare Provider:</u>

* Healthcare Provider *Signature*: _____
* Healthcare Provide (PRINT): _____DATE:_____ PHONE:_____

TO BE COMPLETED BY PARENT OR LEGAL GUARDIAN ***(This portion must be signed with SBH Nurse present in front office)***

I hereby give my permission for my child (name above) to receive this stated medication at school.

I assume full responsibility and will inform school staff of any medication changes or health status. I hereby release SBH Board, their agents and employees from any and all liability that may occur as a result of any medication administration. **I will provide a new medication form each school year and each time the dose/medication changes. I agree to furnish medication in an original, property labeled pharmacy or store container. I will pick-up unused/discontinued medication in an original property labeled pharmacy or store container. I will pick-up unused/discontinued medication as needed during (or by the end of) the school year.**

***Parent/Legal Guardian Signature**: _____ **Date:**_____
Daytime Phone Numbers: _____Work Phone Numbers:_____

<u>Bus Driver Notified</u>: __ YES __NO __N/A

- Student demonstrated adequate knowledge to keep, carry and take this medication

School Nurse: _____ Date:_____
***Reviewed and Witness by th**e _____
School Nurse Date

SBH0805