TRINITY CHRISTIAN ACADEMY
True Education

Permission Form for Prescribed or Over-the-Counter Medication

School personnel who accept the delegation of medication administration and successfully complete the medication administration course (taught by licensed personnel), including demonstrated competency, are protected from liability under KRS 156.502.

COMPLETED BY SCHOOL: Trinity Christian Academy
Student's Name: _____ Grade: _____ Homeroom/Classroom: _____
Student's Age: _____ Date of Birth: _____

TO BE COMPLETED BY THE PHYSICIAN/HEALTH CARE PROVIDER FOR PRESCRIPTION MEDICATION
Name of medication: _____Reason for medication: _____
Form of medication/treatment: Tablet/capsule Liquid Inhaler Injection Nebulizer Other _____
Describe schedule and dose to be given at school: _____
Starting Date: Date form received Other, as specified: _____
Stopping Date: For episodic/emergency events only End of school year Other date/duration:_____
Restrictions and/or important effects: _____
Please describe: _____

NOTE: In the event the Principal/designee is notified of the possibility of an adverse or extreme reaction to a medication, s/he shall inform the student's teacher(s) of such a possibility before the student begins the medication schedule.

Special storage requirements: None Refrigerate Other _____
Student is capable of/responsible for self-administering this medication: No Yes Supervised Unsupervised
Student has been instructed in self-administering the medication: No Yes
Student must carry this medication on his/her person: No Yes

Please indicate additional information: On the back side of this form as an attachment.

_____ _____
Physician/Health Care Provider Signature Date

_____ _____
Signature of Parent/Guardian Date

Name of Physician/Health Care Provider:_____
Address: _____
Phone #: _____ Fax #: _____
Date form received by school _____