MADISON COUNTY SCHOOLS

MEDICATION PERMISSION REQUEST FORM

Medical Action Plans are required for Asthma/Diabetes/Life-Threatening Allergy/Seizure

School Year

Student's Name:		Date of Birth:
School:	Grade:	Teacher:

The policy of Madison County Schools states that any student who requires a prescription and/or over-the-counter (OTC) medication of ANY kind during school hours MUST complete A & B.

A. Present this consent form to the office of the principal or the school nurse. Forms are available in each school office and on-line. **Incomplete forms will not be accepted.**

B. Parent/guardian must bring the medication to the school. **No medication will be accepted by the student.**

- The **prescription** medication must be in a container properly labeled by the pharmacist.
- The **non-prescription/OTC** medication must be in the original sealed container.

Each school will have designated personnel who will assist your child with their medication.

☛ New forms must be completed each school calendar year.

☛ All remaining medication must be picked up by parent/guardian no later than the last day of school.

To be completed by Physician

Medication REQUIRED to be taken or made accessible to the student during school hours:	
Time to be delivered:	
Dose to be delivered:	
Route of delivery:	
Length to be taken:	

PHONE NUMBER OF PHYSICIAN OFFICE:	

(PRINTED NAME OF PHYSICIAN)	(SIGNATURE OF PHYSICIAN / DATE)

To be completed by Parent/Guardian

The parent/guardian releases the school district and its employees and agents from liability for an injury arising from the student's self-administration or staff assistance in administration of medication while on school property or at a school related event or activity unless in cases of wanton or willful misconduct.

(PRINTED NAME OF PARENT/GURADIAN)	(SIGNATURE OF PARENT/GURADIAN / DATE)

*****CHANGES TO MEDICATION MUST BE PRESENTED IN WRITING.*****