

Carlisle Local School District

Permit for Dispensing Medication

I request school personnel to administer and/or assist in the administration of medication to my child. Including prescription medication; over-the-counter medication; emergency medications including but not limited to; inhalers, epinephrine pens, diazepam and versed. If determined appropriate by physician, student may carry inhalers and epinephrine pens. School personnel will follow instructions provided by physician and I agree to (1) deliver the medication to the school in the original container with pharmacy label (2) notify the school if I change physicians or if the medication is changed or eliminated. (3) I agree to pick up left over medication when it is terminated or by last day of school or it will be disposed of. I understand it is the student's responsibility to report on time for scheduled medication. I give permission for the school nurse to contact the physician regarding this medication administration in the school setting. I agree to hold school employees and the Board of Education free from all responsibility for results of listed medications.

To be completed by Parent/Guardian:

Name of Student _____ DOB _____
Students Address _____
Allergies _____
Parent/Guardian Signature _____ Date _____
Phone # during School Hours _____ Other Phone # _____

This section to be completed by the physician:

Medication _____
Dosage _____ Time/Frequency _____
IF PRN list conditions needed _____
Adverse reactions to report _____
Special Instructions/Storage _____
Date to begin administration _____ Date to end _____
Prescribing Physician (Print) _____
Physician Signature _____
Physician Address _____

School Staff ONLY:

Nurse Signature _____ Approved _____ Denied _____ Date _____
School _____ Grade _____ Teachers _____