

**Kentucky School for the Blind
2018-2019
Authorization to Give Over the Counter Medication**

Dear Parent/Guardian:

This form is regarding **over the counter medications** given during the school day. **All medication should be given at home when possible.** However, if given at school, the medication will most likely be administered by trained, unlicensed KSB personnel. In order for school personnel to administer any type of medication to your

child, we must have this signed authorization form on file. **Also, for over the counter medication to be given a Health Care Provider's signature is required.**

As a reminder, the first dose of any new medication should not be given at school. Also, before sending any medication(s) to school, please read and follow the directions below.

- All information below must be completed before returning it to school.
- A separate **Authorization to Give Over the Counter Medication Form** must be completed for each medication to be given at school.
- The medication must be sent to school in the **original labeled container.**
- Medications should be brought to school by parent/guardian and will be counted with a trained JCPS staff member. If you cannot personally bring the medication to school, it must be sent in a sealed envelope with the student's name written on the outside. A follow-up call should be made to the school office staff to inform them your child is bringing their medication and to confirm the number of pills. School staff should have another JCPS school staff member witness the phone call and the number of pills will be noted on the Medication Administration Records (MAR). If the envelope is open, NO medication should be given and the parent must come to the school and confirm medication and number of pills. If medication is sent to school in an envelope, the **parent accepts all responsibility while medication is in transit from home to school.**
- At the end of the school year, you will be requested to pick up any unused medication. If medication is not picked up as requested, medication will be appropriately disposed of by school staff and/or district nurses and a witness.
- Medication may be given 30 minutes before to 30 minutes after the time medication ordered.
- If a medication is stopped prior to the "date to stop medication" indicated on this form, you must send a note to the school informing them.
- This form(s) expire(s) at the end of the school year; however, when there are changes to the medication, times, or dosages you will be required to complete a new **Authorization to Give Over the Counter Medication Form.**

Sincerely,

Principal

**Kentucky School for the Blind
2018-2019**

Authorization to Give Over the Counter Medication
(This Form Requires a Health Care Provider's Signature)

Student: _____ Date of Birth: _____
School: _____ School Year: _____

Instructions for giving my child this medication:

1. Name of medication: _____
2. Dosage to be given: _____
3. Specific time of day for dosage: _____
4. Route of administration (e.g., mouth, nose, eyes, ears): _____
5. Special instructions (e.g., take on empty stomach): _____
6. Date to start medication: _____
7. Date to stop medication: _____
8. Reason medication is needed: _____
9. Reactions/side effects: _____
10. Allergies: _____

Printed Name of Health Care Provider

Health Care Provider Signature

Date

Health Care Provider Address

Health Care Provider Phone #/Fax #

I hereby acknowledge that if this medication is not self-administered, it will most likely be administered by trained, unlicensed KSB personnel. I acknowledge and agree when I authorize my child to attend a school sponsored field trip this medication may also be administered by a licensed volunteer. By signing this form, the parent/guardian acknowledges that the Kentucky School for the Blind, its employees and agents shall incur no liability as a result of any injury sustained by the student from any reaction to any medication, unless the injury is the result of negligence or misconduct on behalf of the school or its employees. The parent/guardian shall hold harmless the school and its employees against any claims made for any reaction to any medication or the administration of such medication unless the reaction is due to negligence or misconduct on behalf of the school or its employees. Also, I hereby give permission for the health care provider completing and signing this form to verify this information with KSB and to consult with KSB staff regarding this information.

Printed Name of Parent/Guardian

Signature of Parent/Guardian

Telephone #

Date

Emergency Contact

Telephone #

Relationship

Kentucky School for the Blind
2018-2019
Authorization to Give Prescription Medication

Dear Parent/Guardian:

This form is regarding **prescription medications** given during the school day. **All medication should be given at home when possible.** However, if given at school, the medication will most likely be administered by trained, unlicensed KSB personnel. In order for school personnel to administer any type of medication to your child, we **must have this signed authorization form on file.** As a reminder, **the first dose of any new medication should not be given at school.** Also, **before sending any medication(s) to school, please read and follow the directions below.**

- **All** information below must be completed before returning it to school.
- A separate **Authorization to Give Prescription Medication Form** must be completed for each medication to be given at school.
- The medication must be sent to school in the **original container**, with the prescription label attached. **THE PRESCRIPTION LABEL MUST SPECIFY THE EXACT TIME THAT THE MEDICATION IS DUE.**
- Medications should be brought to school by parent/guardian and will be counted with a trained KSB staff member. If you cannot personally bring the medication to school, it must be sent in a sealed envelope with the student's name written on the outside, and a follow-up call should be made to the school office staff to inform them your child is bringing their medication and to confirm the number of pills. School staff will have another KSB school staff member witness phone call and number of pills noted on Medication Administration Record (MAR). If the envelope is open, **NO** medication should be given and the parent must come to the school and confirm medication and number of pills. If medication is sent to school in an envelope the **parent accepts all responsibility while medication is in transit from home to school.**
- At the end of the school year you will be requested to pick up any unused medication. If medication is not picked up as requested, medication will be appropriately disposed of by school staff and/or district nurses and a witness.
- Medication may be given 30 minutes before to 30 minutes after the time medication is due to be given.
- If a medication is stopped prior to the stop medication date indicated on this form, you must send a note to the school informing them.
- This form(s) expires at the end of the school year; however, when medication, times, or dosages change, you will be required to complete a new **Authorization to Give Prescription Medication.**

Sincerely,

Principal

Kentucky School for the Blind
2018-2019
Authorization to Give Prescription Medication

Student: _____ Date of Birth: _____
School: _____ School Year: _____

I hereby request Kentucky School for the Blind personnel to give the above named student medication that has been prescribed by _____.

Date of last office visit: _____
Health care provider's telephone no.: _____ Fax no. _____
Health care provider's address: _____
Date to start medication: _____ Date to stop medication: _____
Reason medication is needed: _____
Reactions/side effects: _____ Allergies: _____

Instructions for giving my child this medication (these must match the prescription label):

1. Name of medication: _____
2. Dosage to be given: _____
3. **Specific time for dosage** (i.e. 8:00am, 1:00pm, etc.): _____
4. Route of administration (i.e. mouth, nose, eyes, ears): _____
5. Special instructions (i.e. take on empty stomach, crush, sprinkle): _____

I hereby acknowledge that if this medication is not self-administered, it will most likely be administered by trained, unlicensed KSB personnel. I acknowledge and agree when I authorize my child to attend a school sponsored field trip this medication may also be administered by a licensed volunteer. By signing this form, the parent/guardian acknowledges that the Kentucky School for the Blind, its employees and agents shall incur no liability as a result of any injury sustained by the student from any reaction to any medication, unless the injury is the result of negligence or misconduct on behalf of the school or its employees. The parent/guardian shall hold harmless the school and its employees against any claims made for any reaction to any medication or the administration of such medication unless the reaction is due to negligence or misconduct on behalf of the school or its employees. Also, I hereby give permission for the health care provider completing and signing this form to verify this information with KSB and to consult with KSB staff regarding this information.

Printed Name of Parent/Guardian	Signature of Parent/Guardian	Telephone #	Date
Emergency Contact	Relationship	Telephone #	

Equal Opportunity/Affirmative Action Employer Offering Equal Educational Opportunities
