

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 appropriately by physician, students may carry inhalers and epinephrine pens. **Students are not permitted to bring medications to school**, all medications must be brought to the office by an adult. School personnel will follow instructions provided by physicians 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 the 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 _____