THE KING'S ACADEMY

1015 S. Ebenezer Road Florence, SC Phone 843. 661.7464 Fax 843. 661.7647

www.tkaflorence.com

Emergency Medication Permission Form

Student: _____DOB_____Grade_____

Teacher: _____

MUST BE COMPLETED BY PHYSICIAN OR AUTHORIZED HEALTHCARE PROVIDER

Name of Medication: _____
Dosage: _____Time to be given: _____

STUDENT NEEDS TO CARRY EMERGENCY MEDICATION WITH HIM/HER: YES/NO

Student's name:_____has demonstrated competency for the administration of their emergency medication_____.
Healthcare Provider's Signature:_____

Reason for Medication:_____

Restriction and/or Side Effects:_____

Healthcare Provider's Signature:_____Date:_____
Address:_____Phone:_____

TO BE COMPLETED BY THE PARENT/GUARDIAN

We, the undersigned parents of the above named child, request that the medication we have delivered to the school in the original container be administered as prescribed.

The school nurse has our permission to contact the doctor for verification of this information or for clarification of any matter relative to the above. I give permission for the health care provider named above or his/her employees to share information about the medication and my child's health with the school nurse or the principal.

We do further agree to save harmless any school personnel who administer or attempts to assist with the above medication in the manner described. This shall mean we agree not to sue school personnel who administer or attempt to assist with the medication in the prescribed manner, either civilly or criminally, for injury resulting from administering or attempting to assist with the above described medication.

Parent/Guardian Signature:_____Daytime phone #_____

Minds and Hearts Coming Fully Alive in Christ!

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I will bring my medication to school each day in it's properly labeled container. I will use my medication for emergencies only. If I misuse or abuse my medication, my actions will be discussed with my parents and physician. I understand that sharing my medication with others will result in disciplinary action.

Student Signature:_____Date:_____

I understand that my child will carry his/her emergency medication and is responsible for having it when an emergency arises. I understand that school staff will be informed of my child's medical condition so they can assist in carrying out the emergency plan with my child's school nurse. If my child abuses or misuses his/her medication, the school will notify me of the occurrence. The nurse has my permission to contact the physician to clarify the treatment regimen. I acknowledge that The King's Academy and its employees and agents are not liable for an injury arising from a student's self-monitoring or self-administration of medication. I understand that if my child shares his/her medication with other it will result in disciplinary action.

Parent/Guardian Signature:_____Date:_____

Student's Name:_____has demonstrated the use of his/her emergency medication per physician's orders. All staff that has need of knowledge has been informed that the student has medication and is allowed to use it during an emergency situation. All staff that has need of knowledge has been given a copy of his/her emergency care plan. A copy of the emergency health care plan and this permission form will be maintained in the student health record.

School Nurse's Signature:_____Date:_____