Office of the School Nurse

MEDICATION AT SCHOOL

The medication procedure below MUST be followed:

1. **ALL** medication must be kept in the school office.
2. Medication is to be transported by the parent/guardian or other responsible adult.
3. Medication must be in an appropriately labeled prescription container. Please have the pharmacist label two containers, one for home and one for school.
4. The **first dose** of medication is **not** to be administered by school personnel.
5. NO non-prescription medications/over-the-counter medication will be given without written permission from the doctor **and** a note from the parent or legal guardian.
6. Medications to be given for a limited time period **(such as an antibiotic)** must be in a properly labeled pharmacy container and be accompanied by a note from the parent.
7. Students requiring daily medication must have a signed statement from their physician.
8. Medication not picked up at the end of the school year will be destroyed after 30 days.
9. The school district **reserves the right to reject** requests for administering medications.
10. This form **must be completed each school year**.

TO BE COMPLETED BY PARENT OR GUARDIAN

I hereby request and authorize the school nurse, or her designee to give my child: _____

DOB: _____ Gr: _____ the following medication(s) as prescribed by Dr: _____

and to consult with the doctor regarding any concerns or questions in reference to the administration of

_____ during the school year.
(name of medication)

Please list other medication presently being taken by student.

Name of Medication	*Dosage*	*Time Given*	*Side Effects*
1.			
2.			
3.			
4.			

I release school personnel from liability should adverse reactions result from prescribed medication.

Signature:	**Date:**

Phone: (Home)	**(Work)**	**(Cell/Pager)**

TO BE COMPLETED BY Physician/Authorized Prescriber or Dentist

I prescribe: _____ to be given to _____
(name of medication) *(name of student)*

by school personnel during school hours.	**Specific times and doses are:**	
Side effects:	**Diagnosis:**	
Signature:	**Phone Number:**	**Date:**

Please fax to: _____ **RN** **Fax Number:** _____ **Phone Number:** _____