

Parent Request for Giving Medication at School

Student: _____ DOB: _____ Grade : _____ School Year: _____

Reason for medication: _____

Name of medication: _____

Strength of medication: _____

Has the first dose of this medication been administered at home? **YES** **NO**

Form of medication: _____ tablet _____ capsule _____ liquid
_____ inhaler _____ nebulizer _____ other _____
_____ injection _____ topical

Dosage: _____ Route: _____

Time to be given: _____

Start Date: _____ End Date: _____ End of School Year _____ Other _____

Please choose how you would like to be contacted about medication refills.

- By letter sent via student.
 By phone. My phone number is _____.
 By email. My email address is _____.

Please choose how you would like the medication handled at the end of the school year.

- I will pick up the medication from the clinic myself.
 Send the medication home with my child.
 Destroy any unused medication.

****Any unused medication will be destroyed at the end of the school year if left at school.***

All medication, (including over-the-counter drugs), should be delivered to the Health Clinic. It must be in their original container and be properly labeled. Over-the-counter medications should be in unopened containers. Over-the-counter medication will not be given more than 10 times without written authorization from a physician. Prescription drugs and/or "samples" from the doctor must be labeled with the student's name, dosage to be administered, the physician's name, date the prescription was filled and the name of the medicine. The school will not administer any type of medicine that is not FDA approved.

The first dose of a new medication or new dosage must be administered at home where parents can monitor potential side effects and adverse reactions.

We, the parents, authorize the school to assist our child in taking medication and agree that we will not hold liable any member of the school staff or an individual of official capacity who is directed by us (the parents/guardian) and the school administrator to assist our child in taking medication.

I give permission for my child to receive the medication named above according to standard school policy.

(Signature of parent or guardian) (Date)