

ADMINISTRATION OF MEDICATION IN SCHOOL

Any student who is required to take during the school day, a medication prescribed by a licensed physician, ARNP, or a PA shall be supervised by the school nurse or designee.

- a. A written statement from the prescribing licensed prescriber, detailing the medication, dose scheduled time of administration and the side effects to be observed and length of time for the course of treatment.
- b. A written authorization (request) from the parent/legal guardian of the student indicating the desire that the school assist the pupil as set forth in physician's statement.

Physician's statement

I hereby instruct the designated member of the school staff to assist:
 _____ in taking the following medication(s):

(Student name)

Medication	Dose	Route	Time (Schedule)	Duration	Side Effects
1)					
2)					
3)					

Student may carry medication (#____) on person ____ Yes ____ No

**** For asthmatics or those using an inhaler: Baseline Peak Flows: Green____ Yellow____ Red____**

 (Physician Signature)

 (Date)

 (Printed Physician Signature)

 (Phone Number)

 (Fax Number)

PARENT/LEGAL GUARDIAN AUTHORIZATION

I hereby request and give my permission for the school nurse and/or designee to assist my child, _____ in taking the following medication(s) (listed above) prescribed by my physician. I release said person from responsibility for any adverse effects from the medication(s) or from the effects when my child refuses to cooperate in taking said medication(s). I also authorize that if necessary, the school nurse and the above physician may share information relative to the health of my child.

 (Parent/Legal Guardian signature)

 (Date)

Other medications child is currently taking: _____ Please send only enough for one month at a time. Medication must be delivered directly to the school nurse or designee by the Parent/Legal Guardian or responsible adult in the original prescription container from the pharmacy or manufacturer's container.