PARENT/GUARDIAN REQUEST FOR MEDICATION IN SCHOOL

_____ _____/_____
Student Name School Grade

To: Building Principal/Designee:

Please comply with the attached written instructions from our physician, certified registered nurse practitioner or physician assistant regarding the administration of medication for our child.

As the parent/guardian of above named student, I relieve the school district and its employees of any responsibility for the benefits or consequences of the prescribed medication. I acknowledge that the school is not responsible for ensuring the medication is taken.

_____ _____ _____
Date Signature of Parent/Guardian Telephone Number

Medication must be in the student's original labeled container. You may request two labeled prescription containers from your pharmacist, one for school and one for home. The medication may be administered at school only during the regular school day. The medication may be administered by non-medical, school personnel as designated by the superintendent. Medications must be brought to school and picked up by parent/guardian or other adult. Medication orders expire at the end of the current school year.

Students requiring medication to manage pain may safely return to school when their discomfort can be effectively controlled by non-narcotic, "over the counter" medications such as acetaminophen (i.e. Tylenol) or ibuprofen (i.e. Advil/Motrin). Special considerations such as use of elevator and early hallway pass may be addressed with the school nurse.

Acetaminophen (i.e.Tylenol) and Ibuprofen (i.e. Motrin/Advil) can be administered with written parent permission according to the standing orders from the school doctor-see reverse side.

Please allow above student to be given: acetaminophen (Tylenol) ____ or ibuprofen (Motrin/Advil) ____ according to the standing orders from the school physician. Parents-please supply medication in original container to be kept in health room.

Parent/Guardian signature _____ Date _____

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All other medications must have both written parent permission and an order from a licensed health care provider that includes the information below.

PHYSICIAN'S AUTHORIZATION FOR MEDICATION
Authorization For Medication During School Hours

_____ should receive the following prescribed medication during school hours:
(Student's Full Name)

Name of Medication _____ Prescribed Dosage _____

Time Schedule _____ Length of Time (Days/Weeks) _____

Diagnosis/Reason for Medication _____

Potential Reaction/Side Effects _____ Emergency Response _____

For asthma inhalers and Epi-pens ONLY – Is child qualified and able to self-administer? Yes ____ No _____

_____ _____ _____
Date Signature of Physician Prescribing Medicine Prescribing Physician's Telephone Number