_____ Prescription medication

_____ Non-prescription medication

Student's last name _____________________

School/ Teacher ______________________

Franklin Special School District

Student Medication Form

This form is designed to assure parents of the appropriate handling of medication needed by students during the school day. For **prescription** medications, this form must be completed and signed by a licensed prescribing physician and a parent or legal guardian. For **non-prescription** medication, the form must be completed by a parent or legal guardian. A new form is required each time the medication or dosage is changed. All prescription medication must be in the original container with the pharmacy label intact. All non-prescription medication must be in the original, unopened container with the name of the medication and the dosage information clearly legible. Expired medications cannot be administered and replacement must be provided by the parent/guardian. **All medications must be brought to school by a parent/guardian.** It is a violation of state and district policies for any student to carry medications on to school grounds, except for those emergency medications specified under state regulations. All medications must be brought in and picked up by a parent/guardian at the end of the school year. **Medications not picked up cannot remain in the school clinic over the summer and will be disposed of according to state regulations**. The first dose of any new medication is to be given at home.

No medication will be administered to a student without a completed medication form on file.

Name of Student ____ Date of Birth ____/____/____

Medication ____________________________ Dosage _______________ Time ________ Route _______

Quantity provided _________________ Medication expiration date ________________________________

Purpose of medication _________________________ Possible side effects __________________________

Other considerations, allergies, or MD orders ____

Physician Name _______________________ Physician Signature ____________________________

Address ____ Phone number _______________________

I acknowledge that the above-named child is competent to self-administer this medication with assistance from the school nurse, or other designated, trained assistive personnel. I release the Franklin Special School District from any legal claim and assume full responsibility for any adverse reactions my child may suffer as a result of taking or failing to take this medication. The physician providing this medication order has my permission to provide this and other health related information to the school nurse, principal or designated assistive personnel. The school nurse has my permission to provide the physician information regarding this medication order and related health issues.

Date _____________ Parent/Legal Guardian Signature ______________________________________

Parent/Legal Guardian Name ____________________________ Phone Number ________________

Medication received by ____________________________ Quantity _________ Date ______________