

ADMINISTRATION OF MEDICATIONS TO STUDENTS
(Permission Form for Medications)

Note: Parent or guardian must complete the entire form – front and back.

No over-the-counter medication will be dispensed unless provided to the nurse in its original container.

District practice allows over-the-counter medicines to be given for up to five times based on a parent signature. Extended use of over-the-counter medications will require a physician's order. District practice also requires that medicines be given at non-school times if at all possible. Medicine must be in an original container and accompanied by this completed form.

School: _____

Date Form Received by the School: _____

Student's Information

Name: _____ Age: _____ Date of Birth: _____

Homeroom/Classroom: _____ Grade: _____

Medication/Prescription Information

Prescription Medication Over-the-Counter Medication Provided by Parent/Guardian

Has the student been given the first dose of this medication? Yes No

Name of Medication: _____

Reason for Medication: _____

Time(s) to be given: _____

Dates to be given: From: _____ To and including: _____

Form of Medication/Treatment: Tablet/Capsule Liquid Inhaler
 Injection Nebulizer Other: _____

Describe the dose to be given at school: _____

If "as needed," indicate the maximum dosage per day: _____

Are there restrictions and/or important side effects? Yes No

If yes, please describe: _____

Special Storage Requirements: None Refrigerate Other: _____

FILE: JHCD-AF3
Critical

Physician's Information

Physician's Name: _____
Address: _____
Phone: _____ Fax: _____
Physician's Signature: _____ Date: _____

Parental Permission

I give permission for _____ (student's name) to receive the above medication at school.

I also give district employees permission to contact the student's physician directly to provide information on the student's condition or to clarify medication administration instructions. I understand that I have the ultimate responsibility for providing the school with an adequate supply of medication and for informing the school district immediately if any information provided on this form changes or if administration of medication should cease. I release school personnel from liability should reactions result from giving the medication. In case of an emergency needing further attention transport to:

Hospital: _____
Parent's Signature: _____ Date: _____
Home Phone: _____ Work Phone: _____ Cell Phone/Pager: _____
Emergency Phone: _____

Notice

Schools in this district are equipped with pre-filled epinephrine auto syringes that can be administered by the school nurse or other trained personnel in the event of life-threatening emergencies involving anaphylaxis.

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Note: The reader is encouraged to review policies and/or procedures for related information in this administrative area.

Implemented: 07/09/2003
Revised: 03/21/2006; 12/19/2006; 04/16/2013

Brentwood School District, Brentwood, Missouri