S-9: Student Medication Form

SALT LAKE CITY SCHOOL DISTRICT
Your Best Choice

STUDENT INFORMATION

Student Name: _____ Date of Birth: _____ School: _____

Address: _____ City: _____ State: _____ Zip: _____

Home Phone: _____ Mobile Phone: _____ Email: _____

EMERGENCY CONTACT INFORMATION

Name (other than parent/guardian): _____ Phone: _____

PARENT/GUARDIAN RELEASE

O I hereby authorize school staff to administer the medication described below to my child. I understand that a trained teacher or school employee will administer only the medication(s) described below. If the prescription is changed, a new parent consent form and a new health practitioner order must be completed before the school staff can administer the new medication.

Prescription medication must be transported to and from school by an adult, in the current original pharmacy container and label, with the child's name, medication name, administration time, dosage, and health care provider's name. If it is an over-the-counter medication, the medication must be in the original store container. The school nurse may contact the student's health care provider if clarification is needed to administer this medication.

O I authorize my child to carry, be in possession of, and self-administer this medication.

My child and I understand there are serious consequences, which may include suspension or expulsion for sharing any medications and/or supplies with others. See Administrative Procedures for Board Policy S-3: Student Conduct and Discipline.

I agree to meet the parental responsibilities listed above. I understand that school personnel may release personal or medical information about my child in a health-related situation if necessary. **Note:** A new medication form will be required every school year.

Parent/Guardian Signature _____ Date _____

MEDICATION INFORMATION (HEALTH CARE PROVIDER ONLY)

NAME OF MEDICATION	INDICATION	DOSAGE	ROUTE	TIME

The above-named student is under my care:

O In my opinion, this medication is necessary during the school day. Trained school personnel should and will be allowed to administer this medication. Please list any specific training required: _____

O In my opinion, this medication is necessary during the school day. I feel it is medically appropriate for the student to be in possession of and self-administer this medication.

Duration medication is to be administered /or student is allowed to carry the medication: _____

Common side effects: _____

Allergies: _____

NOTICE: This order can only be signed by an MD; Dentist; Nurse Practitioner (NP, FNP, PNP, APRN/PP), Certified Physician's Assistant or a provider with prescriptive practice.

Physician's Signature _____ Phone _____ Date _____

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SALT LAKE CITY SCHOOL DISTRICT MEDICATION RECORD/LOG (INTERNAL USE ONLY)

STUDENT:	PARENT:		YEAR:	TEACHER:	
MEDICATION	DOSE	ROUTE	TIME	DATE BEGAN	DATE ENDED

Staff Signature: _____ Initials: _____ Staff Signature: _____ Initials:_____

Staff Signature: _____ Initials: _____ Staff Signature: _____ Initials:_____

MEDICATION RECORD/LOG

Special Instructions/Notes:_____

(Codes: **X** = No School, **OT** = Off Track, **A** = Absent, **NP** = No Pills Available, **R** = Refused, **PC** = Parents called/notified)

JULY					AUGUST					SEPTEMBER					OCTOBER				

Notes: _____

NOVEMBER					DECEMBER					JANUARY					FEBRUARY				

Notes: _____

MARCH					APRIL					MAY					JUNE				

Notes: _____