MEDICATIONS AT SCHOOL: PARENT INSTRUCTION GUIDE

IMPORTANT MEDICATION INFORMATION

To safeguard the transportation of medication to and from school, Pre-K thru grade 8, prescription and over the counter medication must be brought into the health center by a parent or guardian. Grades 9-12 prescription and over the counter medication (if sent to school with student) must be sent in a sealed envelope in its original container.

Student's requiring a refill will have an empty medication bottle sent home along with a copy of the MVCSC Refill Medication Form. Medication shall be returned/transported as specified above.

All medications must have an MVCSC medication permission form (back of this guide) completed and on file prior to administration.

Students are not permitted to carry any medication without a physician's statement in writing.

Any unused medication unclaimed by the parent by the last student day of school will be destroyed. Grades 9-12 are able to transport unused medication with written permission from parent or guardian (see medication permission form).

FDA approved medication at school must include:

For over the counter medication (includes cough drops) - it must be in the original package with the dosing information present. The nurse can only give the dose listed on the package label. If your medical provider has ordered your child to take more than the dose on the package label it would be considered a prescription dose. The school nurse will need a prescription order from your medical provider.

For prescription medication- it must be in a prescription bottle with the most current dosing information and the student's name on the label along with a written order from your medical provider.

Additional information can be found in the MVCSC Health Services Handbook located on the Health Services home page at https://www.mvcsc.k12.in.us/Administration/healthservices.

Please call the nurse at your school if you have any questions.

The Medication Permission Form must be filed with the student's Health Services or designee **annually**.

Mt. Vernon Community School Corporation

Medication Permission Form

Student's Name____ Grade__________ DOB________________

Parent/Guardian Name____ Phone__________________________

School______________________________________ Start Date __________________ End Date ________________

Physician Name____ Phone_________________ Fax_____________

Medication Name	Dose	Time(s) To be Given	Daily or As Needed	Reason for Medication	Amount of medication provided for school use

NOTE: All prescription medication MUST be supplied in the original, labeled prescription container.
All over-the-counter (OTC) medications MUST be supplied in the original, unexpired container.

Delayed Start Wednesday's: **Hold Medication on DS Wednesday's Yes_____ No_____**
Give Medication at same time on DS Wednesday's. Yes_____ No_____
Give Medication at a different time on DS Wednesday's. Time to be given ________ am/pm

Parent/Guardian Authorization

1. I request that the above medication(s) be given during school hours as indicated above.
2. I will notify the school clinic of any change in the medication(s), i.e., dosage change, medication is stopped, etc.
3. I give permission for the medication(s) to be given by trained school personnel when delegated by the school nurse in his/her absence or while attending a field trip.
4. I release school personnel from liability in the event adverse reactions result from taking this medication.
5. This consent may be revoked at any time by sending a written notice to the school nurse.
6. I agree to the grade appropriate MVCSC transportation of medication policy found in the Health Services Handbook and provided with this form.

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Parent/Guardian signature Date

Permission for Release of Information

1. I give permission for the school nurse to communicate, as needed, with appropriate school staff about the above medication(s).
2. I give permission for the school nurse to consult with my child's physician/licensed prescriber about any questions regarding the listed medication(s) and/or medical condition(s) being treated by medication(s).
3. I give permission for the physician/licensed prescriber to release information related to the above medication(s) and medical condition(s) to the school nurse.

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Parent/Guardian signature Date

For High School Students ONLY (Grades 9-12)

I give the MVHS clinic staff permission to send the above medication home with my child at the end of the school year or when this medication is no longer needed to be given at school.

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Parent/Guardian Signature Date