DUNKLIN R-5 SCHOOL DISTRICT

497 Joachim Ave, Herculaneum, MO 63048

Phone: (636) 479-5200

High School: Nurse Ext.4007 Fax: 636-479-2051 Middle School: Nurse Ext. 2007 Fax: 636-479-7219

Pevely Primary: Nurse Ext. 3007 Fax: 636-479-7804 Taylor: Nurse Ext. 5104 Fax: 636-479-2053

School Medication Prescriber/Parent Authorization

Student Information:

Name of Student: ____ D.O.B.__________(MM/DD/YY)
Name of School: ____________________________ Grade: __________ School Year:_______________
List of known drug allergies/reactions: ____
Height (in): Weight (lbs.):

FOR COMPLETION BY PRESCRIBER

Diagnosis:____
Medication: ____________________________ Dosage:__________ Route: _________ Frequency:________
Time of Administration at School: _____________________ Lunchtime If PRN. Frequency:___________
PNR, for what symptoms: ____
Medication shall be administered from: ___________________ to ____________________ (mm/dd/yy)
Special Instructions:
Does medication require refrigeration YES / NO
Is medication a controlled substance: YES / NO

For Inhaler. Epi-pen, and Insulin ONLY:

Is self administer permitted and recommended for this student YES / NO
Is self-carry permitted and recommended for this student: YES / NO
I hereby affirm that this student has been instructed in the proper self-administration of the prescribed medication(s).

Potential Side Effects/Contraindication/Adverse Reactions: __________________________

________________________ ____________ ____________ ________________

Signature of Prescriber (no stamps) **Date** **Phone** **Fax**

COMPLETION BY PARENT/GUARDIAN:

In order for my child to receive medication in school, I agree to the following:

- All prescriptions and non-prescription mediation will have a physician's signed order FULLY completed for each school year.
- The prescription medication will be in a container labeled by the pharmacist or physician with: (Name of child, name of medication, dosage, routes, time of administration, name of physician, prescription date, expiration date, and conditions for proper storage.)
- The non-prescription medication will be in the original seal container with the label intact. The student's name will be put on the container in a position not to obscure the label.
- The medication will be brought to school by an adult.
- The physician will be called in a question arises about my child's medication/medical health.
- The first dose of this medication (except for Epi-pen) has been given without problems.

Having read the able conditions, I request the Dunklin R-5 School District Health Services personnel administer the medication as prescribed by the physician listed above. I certify that I have legal authority to consent to medical treatment for the student names above, including the administration of the medication at school.

Signature of Parent/Guardian: ________________________________ **Date:**______________

Relationship to student: _______________________ **Phone Number:** __________________