Strasburg School District No. 31J
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STUDENT MEDICATION FORM

Non-Prescription medications

Non-prescription medications will NOT be administered at school without a signed form from the physician and the parent, thereby making it a prescription medication. This includes Tylenol, cough syrup, cough drops or any other over the counter medicine. Over the counter medications must be brought to school in their original boxes, clearly marked with the child's name.

PRESCRIPTION MEDICATIONS

Prescription medications are administered at school only when the following form is completed and signed by the parent or guardian and the physician. (It is permissible for the physician to substitute a signed instruction form if you do not have this form available at the doctor's office). Instructions must include the child's name, the name of the medication, dosage, time it is to be given and for how long. Prescriptions must be up-to-date. The medication must be brought to school in its original container appropriately labeled by the pharmacy or by the doctor's office. This includes inhalers. The instructions on the label MUST match exactly the instructions given by the physician.

Name of Student _____

Medication _____ Dosage _____

Purpose of Medication _____

Known Side Effects _____

Time of Day/Frequency Medication is to be given _____

How many days or how long medication is to be given _____

_____
Physician's signature date

SELF-ADMNISTRATION OPTION – (NOT AN OPTION FOR CONTROLLED DRUGS.)

The student has my consent to self-carry his/her medication. I understand the school will not be responsible for the administration or supervision of the medication. It is strongly suggested that back-up medication be available in the office should the student not have medication available, (especially for inhalers.). I understand the school has the right to withdraw this privilege if the student does not show he/she can handle the administration in a proper manner. The student shall not share or distribute medication to any other students. Permission requires both parent and physician signatures.

_____ _____
Physician signature date Parent signature date

PARENT PERMISSION:

*I hereby give my permission for _____ to take the above medication at school as prescribed. I understand that it is my responsibility to furnish the medication. I understand the medication must be brought to the school by an adult, especially if the medication is a controlled substance.

*I give my permission for the school and health provider to exchange information as it relates to the condition under treatment.

*I further acknowledge that this medication is being given at my expressed request and therefore release the school district, its representatives, and the employees from any liability or loss related to the administration of this medication

_____ _____
Physician Name Physician phone #

_____ _____
Parent/Guardian signature date daytime phone number