NORTH CLACKAMAS SCHOOL DISTRICT
MEDICATION ASSISTANCE

Student's Name	**Date of Birth**
School	**Teacher Name/Grade**

I request that school staff assist my child in the administration of this medication in accordance with our health care provider's written instructions.

1. Diagnosis (indication for medication or emergency injection): _____
   _____
2. Medication prescribed: _____ Expiration Date: _____
   Dosage: _____ Frequency/time: _____
3. Possible reaction to medication: _____
4. Other specific instructions: _____
5. Date to discontinue medication: _____

The medication/emergency injection herein is required to be scheduled during school hours.

- Medical treatment is the responsibility of the parent and the health care provider. Administering medications is a service the school is not legally required to perform. However, when it is absolutely required that a medication is taken at school by a student, this form, with specific instructions from the health care provider and the parent's/guardian's signature, is required.
- It is understood that the school is not legally obligated to assist in administering medication to my child. Therefore, I agree to hold the school district and its employees free from any and all responsibility for the results of such medication or the manner in which it is administered, and to indemnify each of them against loss by reasons of any civil judgment arising out of these arrangements which may be rendered against them.
- I will notify the school immediately if we change health care providers or if the medication is changed or stopped. Changes in dosages must be verified by a health care provider. If notified by school personnel that medications remain after the course of treatment or at the end of the school year, I will collect the medication from the school or understand that it will be properly disposed of.

Medication <u>must</u> be supplied in the original pharmacy container.

Signature required on back of form.

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The health care provider's signature is required for prescription medication (may be in the form of a current Rx label).

Health Care Provider's Signature	Health Provider's Name (Printed)
Health Care Provider's Phone #	Date

STUDENT MEDICATIONS

If medication (prescription or non-prescription) is required in order for the student to remain in school, the following procedures are in effect:

1. The parent/guardian must complete this Medication Assistance form before medication can be given.

2. A physician's signature is required for all PRESCRIPTION medications. (This may be in the form of a prescription label if all information is complete.) All medication must not be expired, and in the original container. The prescription label must be current and include the student name, medication name, dosage instructions and the physician's name and phone number.

3. The parent/guardian must provide all supplies necessary for proper administration of the medication (i.e., measuring devices and pre-cut pills).

4. All medication will be kept in a locked area and dispensed only by trained staff. Teachers will not store or dispense medications from their classrooms.

5. All non-prescription medication required during school hours, necessary for a child to remain in school, require completion of this Medication Assistance form. The medication must not be expired and must be contained in the original labeled container including instructions.

I have read and understand the information on this form. I have received a copy of this form.

Parent's Signature	**Daytime Phone Number**	**Date**