Wright City Middle School
100 Bell Road
Wright City, MO 63390
Phone: 636-745-7403
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Medication Form for Grades 6-8

Students Name: _____ DOB: _____ Grade: _____

Administrative procedures for Giving Prescription & Non-Prescription Medicine in School

Prescription medicines will be in the original pharmacy/prescriber label container showing: a.) student's name b.) name of medicine c.) dosage and administration schedule d.) prescriber's name and e.) date purchased. The student's authorized prescriber is a **medical professional** with prescriptive authority such as a physician, dentist, orthodontist, etc. **The district will not administer the first dose of an initial prescription.**

Procedure for the administration of prescription and non-prescription medicine:

1. The following form must be completed, signed and dated by the **prescriber and parent.**
2. Medication will be provided in the **original container** appropriately labeled for the prescription. The non-prescription container must have the manufacturer's original packaging and will only be administered in accordance with the manufacturer's label. **Note:** Ask the pharmacist for an extra labeled container so you can have one for school and one for home.
3. All medication is to be brought to school by a parent or guardian to the school nurse or principal.
4. The district will administer parent provided non-prescribed medicine upon written permission from parent/guardian according to the following schedule: Up to 6 doses per semester. Further dosage will only occur with written doctor's permission.

TO BE COMPLETED BY PHYSICIAN:

Medicine: _____ Dose: _____ Route: _____

Time/interval to be given: _____ Start date: _____

Known Drug Allergies: _____ Discontinued date: _____

Possible Side Effects to be observed: _____

Diagnosis/Indication for use: _____

(Signature of parent/guardian below gives permission to release this information)
I request that the Wright City R2 School District administer this medicine to this student.

_____ _____ _____
Printed Name of Physician Signature of Physician Date

_____ _____
Address of Physician Physician Phone Number/Fax Number

TO BE COMPLETED BY PARENT/GUARDIAN:

I give permission for the above medication to be administered to my child by designated personnel. I also give the district employees permission to contact the student's physician directly to provide information on the student's condition or to clarify medication administration instructions. I understand that I have the ultimate responsibility for providing the school with an adequate supply of medication and for informing the school district immediately if any information provided on this form changes or if administration of medication should cease.

_____ Date: _____
Signature of Parent/Guardian