ADMINISTRATION OF MEDICATION DURING THE SCHOOL DAY

MONTICELLO PUBLIC SCHOOLS HEALTH SERVICES

Student's name _____ DOB_____ Grade/Teacher_____/_____

Parents of pupils requesting that any prescription medication (or OTC medication beyond the recommended dosage) be administered during school hours by school staff are required to provide for the school:

1) The **Physician's order**,
2) A **Parental release**, and
3) Medication supplied in the **original container**.

PHYSICIAN'S AUTHORIZATION

I have prescribed the following medication for this student and request that dosages be administered during school hours:

Diagnosis	Medication	Strength	Dose	Time	Route	Possible Side Effects
_____	_____	_____	_____	_____	_____	_____
_____	_____	_____	_____	_____	_____	_____

Special Instructions _____Start Date: _____ Stop Date: _____

Print Physician's Name/Clinic _____

Physician's Signature _____Date _____ Phone _____

PARENTAL REQUEST FOR ADMINISTRATION OF MEDICATION

I request this medication be given as prescribed and I give the Health Services Staff authority to communicate with the ordering physician about this medication. I release school personnel from any liability in the administration of this medication at school. I understand that medication will be administered by the designated personnel as delegated by the school nurse.
Please check the appropriate spaces below:

1) _____ Keep this medication at school _____ Send this medication home each afternoon
2) Physician and I agree this student needs medication on field trips. Yes _____ No _____
3) I give permission for my child to receive their daily morning medication at school on 1-2 hour late start school days. Yes _____ No _____
4) If your child has remaining medication(s) in the health office at the end of the school year, we prefer you pick them up. If you are unable to pick up the medicine(s) and would like us to send home with your child, your written permission is required (OTC and inhalers only). Please indicate below which plan we are to follow.
   - ❑ **Plan A (preferred):** I will pick up my child's medication at school.
   - ❑ **Plan B:** Please send the medication with my child (note required).

Parent/Guardian Signature _____ Date_____ Phone _____