

**NACS GUIDELINES AND CONSENT FOR MEDICATION AND TREATMENT**  
**ADMINISTRATION**

**These Guidelines are for all Prescription Medications/Treatments and Nonprescription (Herbal-Vitamin-Dietary) Medications/Treatments**

- All medications must be brought to school and taken home by a parent/guardian.
- All medications must be kept locked in the clinic during the school day, with the exception of inhalers and Epi-pens. A child may carry and self-administer these prescribed medications if the nurse has written permission by a physician.
- When possible, schedule doses of medications to be given at home and not at school.
- NACS is not responsible for adverse reactions of medications when given according to the physician's or manufacturer's instructions.
- All medications must be in the original container with a label and child's name printed or written on it.
- Send only the amount of medication needed at school, keep the remainder at home in another container.

**I will comply with the above guidelines and I give permission to the school nurse, or school personnel designated by the nurse, to give the medication/treatment listed below. I give permission to the school nurse to share with the appropriate school personnel information relative to the medication/treatment, e.g. adverse side effects, as he/she determines necessary for my child's health and safety.**

Child's Name \_\_\_\_\_ Grade \_\_\_\_\_ Date of Birth \_\_\_\_\_

Diagnosis for which medication/treatment is ordered \_\_\_\_\_

Name of medication/treatment \_\_\_\_\_

Dose to be given \_\_\_\_\_ Time to be administered \_\_\_\_\_

Date to start medication/treatment \_\_\_\_\_ Date to stop medication/treatment \_\_\_\_\_

Form of medication/treatment: Tablets/capsule \_\_\_\_\_ Liquid \_\_\_\_\_ Inhaler \_\_\_\_\_ Injection \_\_\_\_\_

Nebulizer \_\_\_\_\_ Other \_\_\_\_\_

I want my child to receive his/her medication on days when school is delayed. Yes \_\_\_\_\_ No \_\_\_\_\_

**Parent/Legal Guardian Signature** \_\_\_\_\_ **Date** \_\_\_\_\_

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**FOR POSSESSION AND SELF-ADMINISTRATION OF MEDICATION**  
**PHYSICIAN MUST COMPLETE**  
**(Inhalers and/or Epi-Pens)**

I have instructed this patient (with return demonstration) in the proper way to administer his/her medication. It is my professional opinion that he/she should be allowed to carry and self-administer this medication.

Physician's Name (*printed*) \_\_\_\_\_

Physician's Signature \_\_\_\_\_