School Year ______________

# MEDICATION ADMINISTRATION FORM
# (FORM TO GIVE MEDICATIONS AT SCHOOL)

STUDENT NAME ___________________________________________________ BIRTHDATE_____________________

PRESCRIPTION MEDICATION TO BE GIVEN AT SCHOOL

☐ I request the following medications, that I will provide, to be given at school as prescribed by my student's provider. I understand that the medications need to be in the original containers and will be distributed per the instructions on the label. Exact timing of medication distribution will be coordinated with the Health Office and the student's teacher. I understand that a parent or legal guardian is required to retrieve the medication at the end of the school year or when requested by the school. I authorize the school district to transport and dispose of any medication that remains in the possession of the school after the requested retrieval date. For controlled substances, any medication that is not picked up will be released to the County Sheriff's Department for proper disposal.

| Medication | How Much (dosage) | When given (how often) | What is it for? |
|---|---|---|---|
| | | | |
| | | | |
| | | | |
| | | | |

OVER THE COUNTER MEDICATIONS AT SCHOOL

☐ I request the following over-the-counter medications, that I will provide for my student, to be kept and distributed to my student per instructions on the container. I understand that a parent or legal guardian is required to retrieve the medication at the end of the school year or when requested by the school and authorize the school district to transport and dispose of any medication that remains in the possession of the school after the requested retrieval date.

| Medication | How Much (dosage) | When given (how often) | What is it for? |
|---|---|---|---|
| | | | |
| | | | |
| | | | |
| | | | |
| | | | |

PARENT/GUARDIAN SIGNATURE_________________________________________DATE____________________

***The 2nd page of this form must be filled out by all parents/guardians at least one time per year.

Lakeview Health Services

School Year _______________

## PARENT/GAURDIAN APPROVAL STATEMENTS
## FOR OVER-THE-COUNTER MEDICATIONS IN THE HEALTH OFFICE

(Recommend to update annually with registration and as needed)

* The Health Office tries to stock some basic over-the-counter supplies to help your students as needed at school. I authorize the Health Office to administer the following over-the-counter medications if needed for my student:

antibiotic ointments (Bacitracin) ☐ yes ☐ no anti-itch creams/gels ☐ yes ☐ no

burn cream(gel)/topical lidocaine ☐ yes ☐ no oral pain relief (Orajel) ☐ yes ☐ no

rewetting eye drops ☐ yes ☐ no cough drops ☐ yes ☐ no

* If school policy allows and the medications are available in the Health Office, do you authorize the Health Office to administer the following oral medications?

Acetaminophen(Tylenol) ☐ yes ☐ no Ibuprofen(Advil, Motrin) ☐ yes ☐ no

Diphenhydramine(Benadryl) ☐ yes ☐ no Cetirizine (Zyrtec) ☐ yes ☐ no

Calcium Carbonate (Tums) ☐ yes ☐ no

Students Grades 7-12 only

* I authorize my student to have on them and self-administer small amounts of over-the-counter medications for their personal use. The student must keep the medication in its original container and use the medication responsibly in accordance to the label. Medications cannot list ephedrine or pseudoephedrine as the only or the primary active ingredient. Liquid cold medications are not permitted to be carried by the student. Cannabis (CBD, THC) containing products are prohibited. I understand that the school district may revoke a student's privilege to possess and use non-prescription medications if the district determines that the student is abusing the privilege. ☐ yes ☐ no

PARENT/GUARDIAN SIGNATURE__________________________________________DATE____________________