FOXCROFT ACADEMY MEDICATION ADMINISTRATION HEALTH CENTER FORMS

STUDENT _____ GRADE _____

SCHOOL _____ BIRTHDATE _____

ALLERGIES_____

Note: Prescription medication must be in the original container indicating the following information: student name, medication, dose, route, time to be administered, and healthcare provider. Over-the-counter medications must be in the original container with clear labeling.

OVER THE COUNTER MEDICATIONS:

Foxcroft Academy must have a signed permission slip on file before your student can receive over-the-counter medication.

The clinic has permission to administer to my son/daughter _____ over the counter medications as listed below:

Tylenol, Ibuprofen, Tums, Cough Drops, and Benadryl (for allergic reactions only) as deemed necessary by the school nurse. If you wish to specify a certain dosage, please do so at the bottom of this release. You will be notified if your child is administered Benadryl.

The clinic may both release and retrieve information from my student's health care provider(s).

Parent or Legal Guardian Signature: _____ Date: _____

PRESCRIPTION MEDICATIONS:

Prescription medications to be administered longer than two weeks must be delivered by an adult in the original container with the student's name, medication name, special instructions, and provider's name. Upon request your pharmacist will provide you with a labeled second container for this purpose. Your written request, as well as the provider's order, must be on file before we can give your child his/her medication.

PARENT STATEMENT: I request that the medication listed below be given to my child named above.

- I understand that whenever possible, the scheduling of medication should be altered to allow the student to receive doses at home.
- I understand that medication must not be expired.

(OVER)

• I understand that in the absence of the school nurse, other trained school staff may administer medication.

• I understand that the school nurse may contact the health care provider or pharmacist regarding this treatment.

• I will notify the school immediately if the medication is changed.

• I understand that this medication will be destroyed per federal DEA requirements unless picked up by the end of the last student school day of this year.

Parent/guardian signature_____Date_____

Home phone _____ Emergency phone_____

Other medications your child is taking_____

HEALTHCARE PROVIDER STATEMENT: This medication is required during school hours to improve or maintain the health of this student. The nurse may contact me regarding this medication. The above-named child should receive prescribed medication for the following condition: _____

Medication name_____ Prescribed dose_____ Dose at school _____

Time given at school_____ Beginning date of medication_____ Ending date_____

Possible side effects_____

Special Instructions_____

Healthcare provider signature _____Date _____

Printed name _____Address_____

Phone _____ Fax _____Email _____

School nurse signature_____Date_____