Beaumont ISD
Preparing Our Next Generation

Policy on Dispensing Medication during School Hours

1. The policy of the Board of Education does not authorize personnel to purchase medicine to give to a student.
2. **Prescription medication** must have written permission from the parent and physician and must include the pharmacy label with student's name, doctor's name, name of medication, instructions for dispensing (amount of dose and time to be given) and prescription number. It must be in the original container. **Over the counter medications** must be in the original container along with a written request provided by the parent. *Medicine given over 5 consecutive days must have written permission from the doctor*. If medicine does not meet BISD policy, the medicine can be destroyed after 2 weeks.
3. Students are not allowed to keep medication on their person except emergency medication (see below).
4. All medication can only be dispensed by the nurse or other designated employee in her absence.
5. Herbal or dietary supplements can only be given if FDA approved.
6. Medication that has expired or is not picked up by the parent at the end of the school year will be destroyed.
7. Please see the school nurse should you have questions, or refer to the student handbook.
8. Rx Medication that is prescribed 3 times a day or less should be given at home unless specified by the doctor.

Request for Administration of Medication during School Hours **Date: _____**

Student's Name:_____ Birth Date _____ School: _____

Condition for which drug is to be given: _____ Drug Allergies _____

Name of Medication: _____

Dosage: _____Frequency: _____

Form of Medication: table☐ pill ☐ capsule ☐ liquid ☐ inhalation ☐ other ☐

Drug Allergies/Remarks/Special Instructions/Side Effects_____

This child has permission to self carry this emergency medication and has demonstrated the skill necessary to self administer this med. **To self carry (healthcare provider initials)** ☐

This is permission to give non prescription and/.or prescription medication to my child named above. I understand that I am giving consent for the school nurse to discuss any concerns regarding this medication with the healthcare provider whose signature appears on this document in order to monitor the healthcare needs of my child.

_____

Signature of Parent or Guardian

Telephone #_____Date:_____

_____

Physician/Adv Prac Name & Number

_____

Physician/Advanced Practice Signature

_____

Nurse Signature

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