

Letter to Parent Regarding Administration of Medication in School

Our school has a written policy to assure the safe administration of medication to students during the school day. If your child must have medication of any type, including over the counter drugs, given during school hours, you have the following choices:

1. You may come to school and give the medication to your child at the appropriate time(s).
2. You may obtain a copy of a medication form ***Request for Medication Administration in School*** from the school website or health office. Take the form to your child's licensed healthcare provider and have him/her complete the form. This form must be completed by the provider for all prescription drugs and over-the-counter medications, the form must be signed by the provider and by you, the parent or guardian. Prescription medicines must be brought to school in the pharmacy-labeled bottle which contains instructions on how and when the medication is to be given. Over the counter drugs must be received in the unopened original container, labeled with your child's name, and will be administered according to the written instructions on the medication at school form.
3. You may discuss with your provider an alternative schedule for administering medication (i.e. outside of school hours). Please keep in mind that scheduled medication will not be given in the first and last hour of each school day.
4. Self-Medication: Students requiring medication for asthma, anaphylactic reactions, and diabetes may self-medicate with physician authorization, parent permission, student agreement for self-carried medication, and a signed blood-borne pathogen/medical waste acknowledgement. Students must demonstrate the necessary knowledge and developmental maturity to safely assume responsibility for, and management of self-carry medications. **If found incompetent by health office personnel, the medication will need to be kept in the health office with the appropriate forms filled out.**
5. School personnel will not administer any prescription or over-the-counter medication to a student unless the school has received a completed *Request for Medication Administration* form that has been signed by both the provider and parent/guardian, and the medication has been received in an appropriately pharmacy-labeled container.

If you have questions about the policy, or other issues related to the administration of medication at schools, please contact the school health office.

Thank you for your cooperation,

Health Office Representative

Date

The Responsibility of the Parent or Legal Guardian

1. Limit the medications that must be given during the school day to those necessary in order to maintain the child at school. ____ *Initials*
 2. Provide a written request for school personnel to administer the medication. This should be in the form of a request/permission form (i.e., Request for Medication form). Return completed form to school. A separate parent request/permission form must be completed for each medication given at School. ____ *Initials*
 3. Parents may choose to administer the medication at school themselves. ____ *Initials*
 4. Complete an Authorization form, signed by a health care provider licensed to prescribe medications, which includes the following:
 - a. Name of child
 - b. Name of medication
 - c. Date it was prescribed
 - d. Dosage
 - e. How the medicine is to be given at school
 - f. When the medicine will be given at school
 - g. Special instructions about the child receiving the medication or about the medicine itself.
 - h. Until what date the medicine is to be given at school
 - i. Possible side effects of the medication
 - j. Possible adverse reactions to the medication
 - k. Name of the health care provider and how to locate or communicate with him/her if necessary
____ *Initials*
 5. Provide a completed action plan form if your child has the following diagnoses and will be self-carrying medication/supplies: Asthma, allergies requiring an Epi-pen, Seizures, and/or Diabetes ____ *Initials*
 6. Provide each medication in a separate pharmacy-labeled container that includes the child's name, name of the medication, the exact dose to be given, the number of doses in the original container, the time the medication is to be given, how it is to be administered, and the expiration date of the medication. The medication pharmacy label on the container must match the doctor's order (request for medication administration).
- Note: The parent should request of the pharmacist to provide two labeled containers – one for home use and one for school use – if child needs to be given medication both at home and at school. ____ *Initials*
7. Over the counter medications administered at school should be provided in their original packaging labeled with the student's name. ____ *Initials*
 8. Provide the school with new, labeled containers when dosage or medication changes are prescribed. ____ *Initials*
 9. Retrieve all unused medications from school when medications are discontinued, and /or within 3 days of the date the school year ends. Signature Preparatory reserves the right to discard the medication if not picked up within 3 days ____ *Initials*
 10. Maintain communication with the school staff regarding any changes in the medical treatment and child's need at school. ____ *Initials*

Student Name: _____ DOB: _____

Parent/Guardian Signature

Date

Health Office Representative

Date



SIGNATURE PREPARATORY

Request for Medication Administration in School

To be completed by physician

Name of Student: _____

School: _____

Medication: (each medication is to be listed on a separate form) _____

Dosage and Route: _____

Time(s) medication is to be given: a.m.: _____ p.m.: _____ PRN: _____

Note: Medication will be given as close to prescribed time as possible but may be given up to one hour before or after prescribed time. Please advise if there is a time specific concern regarding administration.

Significant Information (include side effects, toxic reactions, reactions if omitted, etc.): _____

Contraindications to administration: _____

Physician (printed) Name: _____ Address: _____

Physician Contact Information: Phone: _____ Fax: _____

Physician's Signature: _____ Date: _____

I hereby give permission for my child (named above) to receive medication during school hours; administered by the health aide or director appointed staff. The medication will be furnished by me in the original container, labeled with the child's name and is to be given as stated above. I understand that medication will NOT be accepted if brought in by my child or is loose in a baggie, envelope or other container. I will count the medication with the staff and co-sign off on the medication. I give my consent to Signature Preparatory Academy to contact the prescribing physician and exchange relevant medical information to clarify this medication order. I hereby release the School Board and their agents and employees from all liability that may result from my child taking this medication.

Parent/Guardian signature _____ Date: _____

Please document medication count *with parent present* below:

Date	Medication Name	Count	Expiration Date	Parent signature	Employee initials



SIGNATURE PREPARATORY

Medication Administration Record (2025-2026)

Student Name: _____ DOB: _____

Medication Name/Dosage/Route: _____

Key : A=Absent FT= Field Trip NS= No Show NM= No Medication in office RF= Refused ED= Early Dismissal

separate sheet is used for each medication or treatment

	AUG	SEPT	OCT	NOV	DEC	JAN	FEB	MARCH	APRIL	MAY
1										
2										
3										
4										
5										
6										
7										
8										
9										
10										
11										
12										
13										
14										
15										
16										
17										
18										
19										
20										
21										
22										
23										
24										
25										
26										
27										
28										
29										
30										
31										

Date	Time	Person Administering (Name & Initials)