

_____ Prescription medication
_____ Non-prescription medication

Student's last name _____
School/ Teacher _____

Franklin Special District Student Medication Form

This form is designed to ensure parents that the medication needed by students during the school day is handled appropriately. For **prescription** medications, this form must be completed and signed by a licensed prescribing physician and a parent or legal guardian. For **non-prescription** medication, the form must be completed by a parent or legal guardian. A new form is required each time the medication or dosage is changed. All prescription medications must be in their original containers with the pharmacy label intact. All non-prescription medications must be in their original, unopened containers, with the name of the medication and dosage information clearly legible. Expired medications cannot be administered and replacement must be provided by the parent/guardian. **All medications must be brought to school by a parent/guardian.** It is a violation of state and district policies for any student to carry medications onto school grounds, except for those emergency medications specified under state regulations. All medications must be brought in and picked up by a parent/guardian at the end of the school year. **Medications not picked up will not be stored in the school clinic over the summer and will be disposed of in accordance with state regulations.** The first dose of any new medication is to be given at home.

No medication will be administered to a student without a completed medication form on file.

Name of Student _____ Date of Birth _____
Medication _____ Dosage _____ Time _____ Route _____
Quantity provided _____ Medication expiration date _____
Purpose of medication _____ Possible side effects _____
Other considerations, allergies, or MD orders _____
Physician Name _____ **Physician Signature** _____
Address _____ **Phone number** _____

I acknowledge that the above-named child is competent to self-administer this medication with assistance from the school nurse, or other designated, trained assistive personnel. I release the Franklin Special District from any legal claim and assume full responsibility for any adverse reactions my child may suffer as a result of taking or failing to take this medication. The physician providing this medication order has my permission to provide this and other health related information to the school nurse, principal or designated assistive personnel. The school nurse has my permission to provide the physician information regarding this medication order and related health issues.

Date _____ **Parent/Legal Guardian Signature** _____
Parent/Legal Guardian Name _____ **Phone Number** _____

Medication received by _____ **Quantity** _____ **Date** _____

Franklin Special School District

Medication Refill Log

Student Name: _____ Date of Birth: _____

Medication must be in the original pharmacy labeled container and counted by both the parent/guardian or their designee and the school nurse or other designated staff member.

[illegible]