

Park Rapids Schools Health Service Medication Form

Prescription Medication

Parents of students requesting prescription medication to be given to their child during school hours by school staff are required to provide the school with the following information. All medication MUST be sent in the original container or pharmacy labeled bottle. A Licensed School Nurse will designate persons giving the medication.

Student Name: _____ Date of Birth: _____ Grade: _____

Parent Name: _____ Phone: _____

Physician Order

I have prescribed the following medication for this child and request it is given during the designated school hours.

Medication: _____ Dosage/Time: _____

For the treatment of: _____

Special Instructions: _____

Possible Side Effects: (optional) _____

Physician Signature: _____ Date: _____

Physicians Name: _____ Phone: _____ Fax: _____

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PARENT REQUEST FOR ADMINISTRATION OF MEDICATION

_____ I request this prescription medication to be given as prescribed by the doctor

_____ I request this non-prescription medication to be given to my child

Name of Medication: _____

Dosage and Time: _____

Treatment of: _____

How long to be given: _____

Parent/Guardian Signature: _____ Date: _____

At the end of each school year if prescription medication is not picked up, it will be transported by SRO to the medication box at the jail. All non-prescription medications that are expired will be disposed of.

PARK RAPIDS SCHOOL DISTRICT HEALTH SERVICE MEDICATION FLOW SHEET

Student Name: _____ Date of Birth: _____ Grade: _____

Medication: _____ Dosage/Time: _____

Date Started: _____ Date Discontinued: _____

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of Tab/Date: _____

Staff Initials & Name: _____ / _____ / _____