CACHE COUNTY SCHOOL DISTRICT MEDICATION STORAGE FORM THIS FORM IS ONLY FOR MEDICATION THAT IS ADMINISTERED AT SCHOOL BY NON-DISTRICT PERSONNEL			**RN Approval**	CACHE COUNTY SCHOOL DISTRICT Nursing & Health Services Phone 435-752-3925 Fax 435-792-7796	**Photo**
STUDENT INFORMATION			**Grade:**		
Student:	**School:**	**SY:**	**DOB:**		
Parent:	**Phone:**		**Email:**		
Prescriber Name:	**Phone:**		**Email:**		
School Nurse:	**Phone:**		**Email:**		

Principal and School Nurse acknowledge that the medication below is being stored at the school to be administered by non-district personnel or District RN.

School Nurse Signature:_____ **Date:** _____ **Principal Signature:** _____ **Date:** _____

Parent: To complete the student information section read and sign the section below.

As parent/guardian I request the medication(s) listed below be stored at school to be administered to my student by non-district personnel or District RN is approved following State Laws and District Policy. I give my permission for Cache County School District to store the medication listed below.

I UNDERSTAND:

- Medication will not be administered by school employees.
- Depending upon the type of medication it is the medication It will be stored in a designated locked cabinet or a secure location. This will be according to the State of Utah Medication Statutes for public schools.
- School personnel will gather the medication or unlock the medication upon non-employee or District RN arrival for administration.
- Parent or guardian is responsible for maintaining necessary supplies, medications, and equipment.
- All medication must be transported to and from the school by the parent/guardian.
- Prescription medication must be in the current original pharmacy container/label, with the child's name, medication name, administration time, dosage, and health care provider's name.
- The information contained in this order will be shared with school staff on a need-to-know basis.
- ***Medication inventory will not be tracked by school personnel. If medication is approved and administered by the RN it will be documented.***
- It is my responsibility to notify the school nurse of any change in my student's health status, care, or medication order.

Parent Signature:_____ **Date:**_____

MEDICATION BEING HOUSED AT SCHOOL

Name of Medication:	**Dose:**	**Type of Medication:**

Medication will be kept: ☐ **In the office** ☐ **In the classroom** ☐ **Other:**

MEDICATION CHECK-IN

Health Aide/RN Signature: _____ **Date:** _____ **Witness Signature:** _____ **Date:** _____

MEDICATION CHECK-OUT

Medication Picked up: ☐ **Parent Picked Up** ☐ **Expired** ☐ **Discarded as per school medication policy at the end of the school year**

Parent Signature: _____ **Date:** _____

Health Aide/RN Signature: _____ **Date:** _____ **Witness Signature:** _____ **Date:** _____

Revised 5/5/23