



BRANDYWINE SCHOOL DISTRICT

1311 BRANDYWINE BOULEVARD
WILMINGTON, DE 19809-2306

(302)793-5000
www.brandywineschools.org

LISA A. LAWSON, Ed.D.
SUPERINTENDENT OF SCHOOLS

JASON HELLER
PRESIDENT, BOARD OF EDUCATION

JOHN SKROBOT, III
VICE-PRESIDENT, BOARD OF EDUCATION

Parent/Guardian Request/Permission to Have Medication Administered in School

- Send the medication to school with a responsible adult (18 years or older) if you are unable to take it to school.
- Send the medication in the original container properly labeled with correct name, time, dose and date.
- The prescription and the medication shall be current and long-term prescriptions shall be reauthorized at least once a year.
- Count the tablets (unless the number of tablets is the exact number on the label) or approximate amount of liquid in the bottle.
- All medication in school is to be picked up or it will be discarded at the end of school year.
- Fill out the following information:

If it is necessary for your child to receive medication during the school day, please do the following:

Date _____ Student's Name _____

Medication Name _____

Dose _____ Time _____

Reason for Medication _____

Allergies to any medications _____

Number of tablets sent _____ Amount of liquid _____ Quantity of Med _____

I am aware that the school nurse may need to contact the prescribing healthcare provider or pharmacist relative to the medication/treatment and that he/she is required to use nursing judgment regarding all medication administration. I give my permission for medication administration by the school nurse.

_____ I give permission for this medication to be taken with my child on any school sponsored field trips during this school year. I understand that a nurse or trained staff will assist my child in taking the medication as outlined above.

_____ I give permission for the school nurse to prepare a staff member to render emergency care for my child to administer noted medication if my child shows life-threatening signs and symptoms of the condition as directed by the emergency action plan/orders prescribed by my child's physician.

_____ My child will not require this medication on field trips.

Parent/Guardian Signature _____

Nurse's
Signature _____

Number of tablets/amounts of liquid received: record and initial on back of this form.

It is the directive of the Board of Education that the Brandywine School District shall not discriminate in its employment practices or its educational programs and activities for students on the basis of race, color, religion, national origin, sex, sexual orientation, marital status, disability, age, veteran status or other legally protected characteristic. All policies, regulations, and practices of the District shall be guided by this directive.



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Medication Count Log

This sheet should be used for monthly reconciliation and periodic counts/additions/subtractions.
Please indicate by month and date if the count is the monthly count.

STUDENT NAME: _____ **BIRTH DATE:** _____

Medication Name, Strength, and Dosage _____

Date	Current Count	Addition or Subtractions	Comment	Initials/Initials

Nurse Signature _____ Initials _____

Nurse Signature _____ Initials _____

Parent/Guardian Signature _____ Initials _____

Parent/Guardian Signature _____ Initials _____

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