Central School District #104

Imagine, Inspire, Achieve

Any student who is **REQUIRED** by a **PHYSICIAN** to take medication of any kind during the school day may be assisted by the school nurse or other designated school personnel, if the district has received the following:

1) A written statement from a licensed health care provider, with prescriptive authority, working within the scope of their practice, detailing the method, amount and time medication is to be taken.
2) A written statement from the parent/guardian requesting the school district to assist the student in the manner set forth by the physician statement.
3) The medication shall be in a properly labeled pharmacy bottle.

*A **new** form must be completed each school year and for all medication changes and when medication is discontinued.

All medication must be brought to school by a parent
No medication will be sent home with the student
All medication must be kept in and dispensed from the nurse's office

Physician statement:

_____is under my professional care and is on the following medication:
Student Name

Medication:_____Dosage_____
Method of Administration:_____Time Schedule:_____
Side effects of particular concern:_____
Start Date:_____Discontinue Date:_____
Diagnosis:_____

I recommend that the school nurse or other designated school personnel assist in the administration of this medication during school hours. This medication must be administered during the school day to allow the student to attend school or address the student's medical condition.

Physician Signature **Print Name** **Office Phone Number** **Date**

Parent Guardian Statement:

As the parent/Guardian of the above named student, I request that Central School District #104 assist in carrying out the physician's instructions in the administration of the above named medication during the school day. I further agree that when the medication is so administered, I waive any claims I might have against the school district, its employees and agents, either jointly or severally, from and against any and all claims, damages, causes of action or injuries incurred or resulting from that administration of said medication. I have read the policy and procedures for the administration of medication in Central School District #104 Handbook and agree to abide by them.

Parent Signature **Print Name** **Phone Number** **Date**

No medication (prescription or over the counter) will be administered without the required signatures.

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632-6336