

**Exhibit FCAB-E1 ~ Request To Administer Medication:
Healthcare Provider & Parent Permission Exhibit**

The policy of Harvey Public Schools regarding the dispensation of medication in school is that medication shall be administered only when the student's health requires medication be given during school hours. Harvey Public School's policy on medication requires a written order from a licensed prescriber and authorization from parent/guardian for schools to administer medication. Medications must be in the original container and will be kept in a locked cabinet located in the office. All medications will be administered by trained school personnel.

Trained Medical Designee: _____

School: _____ Phone: _____

I authorize the student below to receive the following medication at school to be dispensed by the designated school personnel.

_____ is to receive
_____ at _____ for the treatment of

Possible side effects: _____

Special Instructions: _____

Estimated date of termination: _____

Physician/Prescriber's Name

Clinic Name

I hereby authorize the trained school personnel to administer the above medication.

Signature of Parent/Guardian

Date

Home Phone

Work Phone(s)

Exhibit FCAB-E2 ~ Self-Administration of non-Asthma Medication at School: Health Care Provider and Parent Permission Form Exhibit

The policy of Harvey Public Schools regarding dispensation of medication in school is that medication shall be administered only when the student's health requires medication during school hours.

Trained Medical Designee: _____

School: _____ Date: _____

The section to be completed by Physician/Prescriber

_____ is to receive

_____ at _____

for the treatment of _____

Possible Side effects: _____

Special Instructions: _____

Estimated Date of Termination: _____

I authorize the student named above to self-administer this medication at school and thereby release the designated school personnel from liability regarding medication administration.

Licensed Prescriber's Name

Clinic Name

Clinic Phone Number

Clinic Fax Number

Parent/Guardian Authorization

1. I/we release the school personnel from liability in the even adverse reactions result from taking the medication(s) by our child outside of the main office.
 2. I/we will notify the school of any change in the medication(s), (*ex: dosage change, medication is discontinued, etc.*) My/our child will sign and follow the agreement with the Trained Medical Designee listed on this form.
 3. I/we give permission for the School Nurse or Trained Medical Designee to consult with the above named student's licensed prescriber regarding any questions that arise with the listed medication(s) or medical condition(s) being treated.
- My child may self-administer their medication as needed.

Parent/Guardian Signature

Relationship to Student

Phone Number

Date

Exhibit FCAB-E3 ~ Student Over-the-Counter Non-Prescription Pain Reliever Medication: Self-Administration Parent Permission Exhibit

I give permission for my child, _____, to self-administer over-the-counter pain reliever medication[s] such as acetaminophen, ibuprofen, aspirin, or naproxen at school. The medication must be in the original container and the medication must be used in a manner consistent with labeling instructions and not shared with any other student. The privilege to self-administer non-prescription pain relievers will be revoked if the student does not follow the above guidelines.

This permission is valid for secondary students for the current school year only.

OTC Medication(s): _____

Parent/Guardian Signature

Date

Home Phone

Work Phone

