FAYETTEVILLE PUBLIC SCHOOLS

Student's name _____ **Date** _____
Teacher/Grade _____
Medication _____ **Dosage** _____
Medication Time _____

Dose Change _____ **Date/Initials** _____

Nurse's signature & initials _____

Date	Mon	Tues.	Wed.	Thurs	Fri.	Date	Mon	Tues.	Wed.	Thurs.	Fri.
8/12/2019	I					10/28/2019					
8/19/2019						11/4/2019					
8/26/2019						11/11/2019					
9/2/2019	H					11/18/2019					
9/9/2019						11/25/2019	H	H	H	H	H
9/16/2019						12/2/2019					
9/23/2019						12/9/2019					
9/30/2019						12/16/2019					
10/7/2019						12/23/2019	H	H	H	H	H
10/14/2019						12/30/2019	H	H	H	H	H
10/21/2019											

Date	Mon.	Tues	Wed.	Thur	Fri.	Date	Mon.	Tues.	Wed.	Thurs	Fri.
1/6/2020	I	I	I			3/30/2020					
1/13/2020						4/6/2020					H
1/20/2020	H					4/13/2020					
1/27/2020						4/20/2020					
2/3/2020						4/27/2020					
2/10/2020						5/4/2020					
2/17/2020	H					5/11/2020					
2/24/2020						5/18/2020					
3/2/2020						5/25/2020	H				
3/9/2020						6/1/2020					
3/16/2020						6/8/2020					
3/23/2020	SB	SB	SB	SB	SB	6/15/2020					

AUTHORIZED MEDICATION GIVERS:
Signature & initials _____

MEDICATION PICK UP BY AND DATE:
_____

FAYETTEVILLE PUBLIC SCHOOLS
Fayetteville, Arkansas 72702

MEDICATION ADMINISTRATION RELEASE FORM

Date: _____

I request that you give medication to my child during the school day in accordance with the policy printed below. You are authorized to delegate this authority to another person if so desired. I will not hold the school staff responsible for any undesired reaction which may occur from this medication.

I agree to pay for ambulance service if used to transport my child from school to the hospital should he/she have a reaction to the medication. By signing this medication sheet, I do give permission for the nurse to contact my child's physician regarding any medication questions.

_____ _____
Parent's Signature **Date**

Student's Name _____

Teacher_____ **Grade** _____

Medication _____ **Dosage** _____

Time to be given _____

For Treatment of _____

Physician _____ **Phone** _____

Parent Name (s) _____ **Phone** _____
_____ **Work (M)** _____
(D) _____
Cell(s)(M) _____
(D) _____

E-Mail Address's M _____ **D** _____

MEDICATION GUIDELINES

1. The medication must be in the original container with the child's name, name of the drug, and directions for use clearly printed on the label. Medication wrapped in Kleenex, foil, baggies, envelopes, or other material will not be accepted.

2. The consent form must be signed before medication will be given at school. Handwritten notes are accepted for the first day only.