Dear Parent/Guardian:

At times, it is necessary for students to be given medications or health related substances at school. A **Request to Administer Prescription Medication Form** must be completed for each prescription medication administered at school. A **Request to Administer Over-the-Counter Medication/Health Related Substance Form** must be completed for each non-prescription drug or substance administered at school including cough drops, salves etc. The applicable form must be filed in the school office and approved before a medication or substance is administered to a student or before a student can take it him/herself. **No exceptions to this policy will be made.**

Prescription Medication	***Over-the-Counter Medication/Substances***
• Prescription Medication Administration form completed and on file in the office. • Form signed in ink by **Parent/Guardian and Physician.** • Prescription medication **in pharmacy bottle/dispenser** with student's name and proper dosage on label.	• Over-the-Counter Medication/Health Related Substance Administration form completed and on file in the office. • Form signed in ink by **Parent/Guardian.** • Medication/substances are in **original manufacturer's unopened package.** • If administering **anything other than the recommended dose, a physician's written approval must be filled out and signed.**

In addition to the policy, we ask that you also follow these more specific guidelines:

1. All medications/health related substances must be brought to school by parent/guardian. **STUDENTS ARE NOT ALLOWED TO TRANSPORT MEDICATION OR HEALTH RELATED SUBSTANCES TO OR FROM SCHOOL.**
2. Parent/students will be responsible for making sure a supply of medication/substance is at school.
3. Parent/guardian should stress the importance of **student responsibility** to take their medication at the prescribed time.

Medication/substances will only be administered by school personnel when all required paperwork is completed, filed in the office, and approved by appropriate school personnel.

Please feel free to call if you have any questions.

Sincerely,

Sara Andrus
District Administrator

Request to Administer Prescription Medication

Complete one form for each prescribed medication. Guidelines on reverse side.

Student's First Name _____ Last Name _____

Date of Birth _____ Sex: ☐ M ☐F

School _____ Grade _____

Parent/Guardian's First Name _____

Parent/Guardian's Last Name _____

To Be Completed by a Physician

Name of Medication/Treatment: _____

Reason for Medication/Treatment: _____

Administration Schedule (include parameters for PRN medications): _____

Dose: _____

Possible Adverse Reactions/Side Effects: _____

For PRN Asthma Inhalers or Epi-pens only, complete if applicable:

☐ No ☐ Yes – This child has been approved adequate instruction and is both capable of and responsible for self-administering this medication.

☐ No ☐ Yes – Due to the severe nature of this child's medical condition, I recommend that this child be allowed to have this medication in his/her possession and to use it as needed.

Date of Expiration _____ Fax _____

Physician's Name _____ Phone _____

Physician's Signature _____ Date _____

I, the parent or legal guardian of the above named student, shall notify the school principal in writing if there is a cancellation of this medication. I understand that I must submit a new request if this prescription changes. I further give permission for designated school personnel to administer the above prescription medication to my child or for my child to self-administer this medication if applicable. This form shall also permit designated school personnel to share and request relevant health information regarding the administration of this medication. I understand that medications are NOT given by licensed medical personnel.

Parent/Legal Guardian Signature _____ Date _____

Administrator Signature _____ Date _____