Policy 4.35FR

MEDICATION ADMINISTRATION CONSENT FORM

Effective: 3/12/2013

Student_____**DOB**_____**Grade**____**School**_____

- Written Parental Consent 4.35 F is required out for any medication to be administered at school.
- Prescription medicine (and non-prescription medicine after 72 hours) requires a licensed Prescriber order**.**
- Medicine must be delivered to the school office by a parent or other responsible adult.
- Medications, including those for self-medication, must be in the original container and be properly labeled with the student's name, the ordering provider's name, the name of the medication, the dosage, frequency, and instructions for the administration of the medication (including times).
- Additional information accompanying the medication shall state the purpose for the medication, possible side effects, and any other pertinent instructions (such as special storage requirements) or warnings.
- Students are not permitted to have medicine in their possession on school property with the exception of listed rescue medications.
- No medication will be sent home with a student, except inhalers . EMPTY prescription medicine containers will be sent home if there is a need for a refill.
- Students who have permission to self-medicate shall store medication in the school nurse office with the exception of listed rescue medications.
- Non-prescription medicine may be given with Parental permission for a total of 72 hours.
  After 72 hours, a physician's order shall be required.
- Medicine shall be given *no more than once* during the school day unless there are extenuating circumstances with order.

PARENTAL PERMISSION FOR MEDICATION AT SCHOOL

I request and authorize that this medication be given to my child during the school day in accordance with school policy by the school nurse or delegated trained school personnel. This medication is in the original container as when it was purchased. The school nurse may contact the prescriber named below in the event of a question or problem regarding this medication during this school year. I certify that at least one dose of the medication has been previously given and NO adverse reactions were experienced. I acknowledge that the District, its Board of Directors, and its employees shall be immune from civil liability for damages resulting from the administration of medications in accordance with this consent form.

Parent / Guardian Signature_____Date _____Parent Phone: _____

Prescriber Name: _____ Prescriber Phone: _____

Medication _____Dose/Instructions_____

Reason for medication to be given at school: _____

PRESCRIBER ORDER MEDICATION ADMINISTRATION

DOES THIS STUDENT HAVE A HEALTH CARE PLAN ON FILE? YES NO

DATE _____DURATION OF ORDER (NOT TO EXCEED CURRENT SCHOOL YEAR) _____

The medication named above is prescribed (Check one): ☐ AS SCHEDULED, OR ☐ AS NEEDED

Time to be given at School (Scheduled) _____ Frequency (As Needed) _____

INDICATIONS (As Needed Med) **OR** COMMENTS: _____

ANY SPECIAL STORAGE INSTRUCTIONS/OTHER INSTRUCTIONS/WARNINGS: _____

POSSIBLE SIDE EFFECTS OR ADVERSE REACTIONS: _____

Prescriber Signature/Title_____ Date_____

INITIAL RECORD OF MEDICATION RECEIVED AT SCHOOL

DATE: _____MEDICATION:_____COUNT/AMOUNT: _____

NURSE/TRAINED SCHOOL STAFF) SIGNATURE: _____

PARENT/DELIVERING ADULT SIGNATURE: _____

School Nurse: Complete REFILL MEDICATION COLUMN ON MAR (side two) when receiving refills of medications.

Obtain parent initials or signature. MEDICATION ADMINISTRATION FORM (MAR) SIDE TWO: FOR SCHOOL USE ONLY