

MCLOUTH USD 342 SCHOOL

Health Services

Medication Administration Request Elementary School

Student Name _____

Date of Birth _____

Allergies _____

Grade _____

Physician _____

School _____

Prescription* (Homeopathic, herbal, natural remedies cannot be delegated without physician's order.)

Medication _____ Dosage _____

Time of Day to be Given, or Schedule _____ Start Date _____

Expected Days of Use _____

Reason for Medication _____

Possible Side Effects _____

Physician Signature _____ Date _____ Phone _____

(Physician Signature is needed only if the current prescription label is not provided)

Non-Prescription (Over the Counter medication including Chap Stick, lotion, creams, cough drops and ointments) All medication must be in original packaging with ingredient and dosing information.

Medication _____ Dosage _____

Time of Day to be Given, or Schedule (please specify)

Medication to be given on a set schedule every _____ hours, or at _____ o'clock

Medication to be given only when needed every _____ hours

Start Date _____ Expected Days of Use _____

Reason for Medication _____

The following is to be completed by the parent/guardian:

The medication must be brought to school in the *original container appropriately labeled with student name*.

Prescription medications must be labeled by the pharmacy or physician, stating the name of the student, the date, the medication, the dosage, and the number of days to be administered.

This request is valid for the current school year only.

*I hereby certify that my son or daughter, named above, has previously **had at least one dose** of the above medications and had no adverse reactions. Initial ____.* I request that this medication be administered at school as directed above. I understand that it is my responsibility to furnish this medication and abide by school policy.

I hereby authorize my child's school's nursing personnel to exchange information regarding this request/medication or this prescription, with the physician or with the pharmacy as identified on the affixed label for purposes of clarification or risk assessment.

Signature of Parent/Guardian _____ Date _____

Medication Administration Policy Provided: **Yes** **NO** **Refused**

School Use:

Prescription Number _____ Pharmacy _____

Prescription Date _____ Staff Initial _____