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 UNOPENED 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. ***It is my responsibility to pick up medication at the end of the school year. Medication left at school at the end of the year will be destroyed.*** _____

This request is valid for the current school year only. Parent signature

*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_____

REV: 04/2022