MCLOUTH USD 342 SCHOOL

Health Services

Medication Administration Request for Secondary Students

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)

Secondary Schools- In the middle school and high school, students and parents are responsible for the administering of all over-the-counter medications. Students should only bring over-the-counter medications to school for personal use, not for the purpose of giving to other students.

Non-Prescription (Over the Counter medication including Chap Stick, lotion, creams, cough drops and ointments, Tylenol, Ibuprofen, Midol, tums and similar OTC medications are all self-carry items)

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_____