Board Policy

Code No. 507.2E2

PARENTAL AUTHORIZATION & PERMISSION FOR ADMINISTRATION OF PRESCRIPTION AND OVER THE COUNTER/NONPRESCRIPTION MEDICATIONS

Student's Name _____Grade_____

Medication_____Dosage_____

Time to be Given_____

Physician_____

Medications are dispensed following these district policies:

1. Label contains: Student name
   Name of medication
   Date of prescription
   Name of physician
   Directions for use
   Duration
2. Authorization is signed by parent(s), guardian(s), or person(s) in charge of student and dated.
3. Medication is in the original labeled container.
4. No over-the-counter medications will be dispensed by school personnel without a doctor's order (i.e., cold remedies, vitamins, etc.).
5. Any changes must be made in writing.
6. Inhalers and Epi-Pens may be kept with the student and self-administered (See Below).

I request the above student be given medication at school according to the prescription or nonprescription instructions and a record maintained.

I agree that school personnel may contact the prescriber as needed and that medication information may be shared with school personnel who need to know.

I agree to provide safe delivery of medication and equipment to and from school and to pick up remaining medication and equipment or it will be properly destroyed. I authorize designated school personnel to dispense my student's routine or emergency medications if needed during field trips.

For Inhalers and Epi-Pens to be Self-Administered Only – enclosed is a doctor's order for medication self-administration and the Authorization-Asthma OR Airway Constricting Medication Self Administration Consent Form to be filled out and returned to the school nurse .

Parent signature_____Date_____

Physician signature (Over the Counter Only):

: _____ Date _____

Please submit this request to the school nurse or principal.

Reapproved: March 5, 2007

Revised: April 2004
May 16, 2005
August 6, 2012
May 4, 2015