USD 320 Request for Medication to be Administered During School Attendance

The USD 320 School District medication policy complies with state law and regulations

This form must be completed before long term prescription or over-the-counter medication is administered at school

- Prescription medications must be brought to school in the original container, appropriately labeled by the pharmacy or physician stating the name of the medication, the dosage, and the number of days to be administered at school
- Any changes in medication, dosage, or schedule will require a new permission form signed by the health care provider and parent/guardian
- The school nurse must review all medication and procedure requests before your child can receive them at school. A non-nurse school employee may be delegated to administer some medications/procedures
- Over-the-counter medications do not require a physician's signature, unless the dose requested is greater than the recommended dose labeled on the bottle
- **Short Term Prescription Medication** that will be given for less than 10 days does not require a physician signature

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Student Name: _____ Grade: _____

Birth Date: _____ Teacher: _____

Medication: _____ Dosage: _____

Medication Start Date : _____ Time to administer: _____

Reason for Prescription: _____

Anticipated number of days to be administered at school: _____

If using an inhaler or EpiPen for treatment of anaphylaxis or asthma, is the student able to self-carry and self-administer as needed? Y N

I hereby give my permission for _____ to take the above medication at school as ordered. I understand that it is my responsibility to furnish this medication and necessary supplies. I further understand that any school employee who administers this medication to my child in accordance with written instructions from the physician/APRN/PA, shall not be liable for damages as a result of an adverse reaction suffered by the student because of administering the above medication. **Your child should have at least one dose of medication without an allergic reaction before bringing the medication to school.** The USD 320 school nurse has my permission to call the prescribing doctor regarding this medication and/or the pharmacy as identified on the affixed pharmacy label.

Date: _____ Parent/Guardian Signature: _____

Date: _____ Physician/APRN/PA Signature: _____

REVIEWED BY USD 320 REGISTERED NURSE: _____