School Year: ____-____

City of St. Charles R-6 School District
400 North Sixth Street, St. Charles, MO 63301
St. Charles High School

Clinic Phone: 636-443-4103 Fax: 636-443-4101

NON-PRESCRIPTION Medication Form for Grades 5-12

ADMINISTRATIVE PROCEDURES FOR GIVING NON-PRESCRIPTION MEDICINE AT SCHOOL
The giving of medicines by the nurse, principal, or designee shall be restricted to necessary medicines that cannot be given on an alternative schedule. All non-prescription medicines will be presented in the **original container with the seal intact.**

Procedure for the administration of non-prescription medicine:

1. The following form must be **completed, signed**, and **dated** by the parent/guardian.
2. **Medication must be provided in the original container with the seal intact.**
3. Only label directions will be followed. Any request in excess of label directions will require a prescriber order.
4. Non-prescription medicine will be permitted in the school or administered in the school *only* in accordance with this procedure.
5. Medicine name, dosage and instructions must be in English.
6. Medication containing **aspirin** will not be given without a doctor's order.
7. **Administration of acetaminophen/ibuprofen is limited to approximately 12 doses per school year, more than this will require an order by an authorized provider.**

Student's Name: ________________________________ Date of Birth: _______________ Grade: ______

Known Drug Allergies: ____

Medicine: ____

Dose and route: ________________________________ Time/Interval to be given: ______________

Diagnosis/Indication for use: ____

Start Date: ______________________________ Discontinue Date: ___________or End of School Year

I request that the St. Charles School District's designated personnel administer the above medicine to my child. I also understand that it is the right of the nurse to refuse to give any medicine that does not meet the criteria established by the St. Charles School District policy.
I give the District nurse my permission to contact my child's healthcare provider if there are any questions or concerns regarding the administration of this medication.
I will inform school personnel of any change in the student's health or change in medication.

____________________________________	________	(____)___________	(____)___________
Parent/Guardian Signature	Date	Home Phone	Work Phone
____		(____)___________	(____)___________
Healthcare Provider (Please print)		Office Phone	Fax Number

MEDICATION FORM MUST BE RENEWED YEARLY

Rev. 7/15