City of St. Charles R-VI School District

Medication Form for PRESCHOOL, GRADES K-4, LEWIS & CLARK, Y.E.S. and R.E.S.

BUILDING:_____ **PHONE: (____)** _____ **FAX: (____)** _____

CONTACT: _____

Administrative Procedures for Giving Prescription & Non-Prescription Medicine in School

The giving of medicine by the nurse, principal or designee shall be restricted to that which is necessary and cannot be given on an alternative schedule. Prescription medicines will be in the original pharmacy/prescriber labeled container showing: **a)** student's name **b)** name of medicine **c)** dosage and administration schedule **d)** prescriber's name and **e)** date purchased. The student's authorized prescriber is a medical professional with prescriptive authority such as a physician, dentist, orthodontist, etc. **The District will not administer the first dose of an initial prescription.**

Procedure for the administration of prescription and non-prescription medicine:

1. The following form must be completed, signed and dated by the **prescriber and parent.**
2. Medication will be provided in the **original container** appropriately labeled for the prescription. The non-prescription container will have the seal intact. **Note:** Ask the pharmacist for an extra labeled container so you can have one for school and one for home.
3. Prescription pills brought to school by a student must have a signed and dated note from a parent/guardian stating the number of pills sent to school. The pills must be taken to the clinic by the beginning of classes that day.
4. Prescription and non-prescription medicine will be permitted and administered in the school ***only*** in accordance with this procedure.
5. Medicine name, dosage and instructions must be in English.

Student's Name: _____ Date of Birth: _____ Grade: ____

TO BE COMPLETED BY PHYSICIAN:

Medicine, dose, and route: _____

Time/interval to be given: _____ Start date: _____

_____

Known Drug Allergies: _____ Discontinue date: _____

Possible Side Effects to be observed: _____

Diagnosis/ Indication for use: _____

(Signature of parent/guardian or independent student below gives permission to release this information.)

I request that the St. Charles School District administer this medicine to this student.

Printed Name of Physician	Signature of Physician	Date

Address of Physician	(____) Phone Number of Physician
	(____) Fax Number of Physician

TO BE COMPLETED BY PARENT/GUARDIAN:

I request that the St. Charles School District's designated personnel administer the above medication to my child.

I also give permission for the authorized prescriber to release the required information for safe administration of this medicine at school. I understand that the nurse has the right to question any medication order she deems potentially inappropriate, and to verify the validity of any medication order. I also understand that it is the right of the nurse to refuse to give any medicine that she feels does not meet the criteria established by Nursing Procedure and the St. Charles School District.

I will inform school personnel of any change in the student's health or change in medication and understand that an additional written request for any change of this medicine must come from the authorized prescriber.

Parent/Guardian Signature	Date	(____) Home Phone	(____) Work Phone