Dorchester School District Four
SCHOOL HEALTH PROGRAM
PERMISSION FOR MEDICATION

ALLERGIES :

PLEASE HAVE YOUR DOCTOR FILL OUT

Name: _____DOB_____

School: _____Grade: _____Teacher: _____

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Medication: _____

Dosage: _____

Purpose of Medication: _____

Time of day medication is to be given: _____

Please indicate where the morning dose will be given: _____Home _____School

Possible side effects: _____

Anticipated number of days medication needs to be given at school: _____

THIS IS A STATE REQUIREMENT: DOCTOR MUST SIGN THIS FORM BEFORE ANY MEDS ARE GIVEN AT SCHOOL!!!

_____ **ICD10 CODE**:_____
Physician

_____ _____
Address SIGNATURE OF LEGAL PRESCRIBER

_____ _____
Phone DATE

PARENT /GUARDIAN MUST SIGN BELOW:

I, the undersigned, ask that the above medication be administered to my child as directed and hereby release everyone participating in this request from any and all liability associated therewith or stemming there from. When the school nurse is not available, the school principal's designee will assist your son/daughter in taking his/her medication. A parent or responsible adult, NOT THE STUDENT, must bring in all medications.

I hereby give my permission for _____to take the above Prescription at school as ordered. I understand that it is my responsibility to furnish this medication and the container will be labeled with the name of the student, the name of the medication, amount to be given, time of day to be given, and physician's name, if prescribed medication. I understand that nonprescription medication must be in the original container. When changes are made in medication, dosage or time, a statement from the prescribing doctor must be provided to the school before this change is made at school. I understand that school officials cannot be held liable for adverse effects from this medication. Parents are responsible for medication until it is received by the nurse or other school personnel.

_____ / _____ / _____ **_____**
Date **SIGNATURE OF PARENT / GUARDIAN**

Parent/Guardian Phone Numbers:
Home:_____ Cell:_____
Work:_____ Other:_____

Medication Amount received:_____ Nurse Signature_____

DORCHESTER SCHOOL DISTRICT FOUR

Guidelines and Procedures for Medications in the School Setting

1. Medications are to be brought to the school by a parent/guardian. All CONTROLLED medications are counted in the presence of the parent/ guardian and the parent/guardian must sign acknowledging that the count is correct. Medications are not to be sent by students and will not be sent home by students. Students will also be required to sign for medications every time they are administered to the student.

2. Any prescription or over the counter medication brought to school by the parent must be in its original container and labeled with the student's name.

3. Written permission is required from the parent and the doctor prescribing the medication. Over the counter medications also require a doctor's order. The school permission for medication form will be completed by the parent and also requires the doctor's signature that prescribed the medication. A copy of the prescription may also be accepted. The permission for medication form is available online at the district's website and will be placed in local doctor's offices.

4. When changes are made in medication, dosage, or time, a statement from the prescribing doctor must be provided to the school before this change is made at school.

5. The first dose of a medication that a student has not taken before should be given by the parent/guardian at home so that the student can be monitored closely for side effects.

6. Medication permission forms and medication orders must be updated at the beginning of each new school year and when changes are made to the student's medication.

7. Medications should be picked up by the parent/guardian at the end of the school year. Medications not picked up will be discarded.