HENDERSON COUNTY PUBLIC SCHOOLS

REV (7-17)

Medication Administration Authorization

Student's Name_____DOB_____
School_____Teacher _____ Physician/Medical Provider_____

I hereby request that my child receive medication during school hours. I hereby release the School Board and their agents and employees from all liability that may result from my child taking the medication listed below. I hereby authorize my physician/medical provider to release to the school nurse specific, confidential medical information contained in his/her record about my child. This information will be used by school staff to deliver health care services to my child in school.

_____ _____ _____
Parent/Guardian Signature Phone Number Date

Medication Name_____**Dosage**_____
Time(s) medication is to be given: a.m._____p.m._____PRN/As Needed Frequency_____
To be given from (date)_____to_____ (Authorization is valid for current school year only)

Significant Information (including side effects, toxic reactions, omission reactions):_____
_____
Contraindications for Administration:_____

If student becomes ill during the school day, school officials are to:

1. ContactParent_____Or Emergency Contact _____
2. Call 911 for life threatening emergencies
3. Inform school nurse of incident

This medication will be furnished by parent or guardian in a container properly labeled by a pharmacist with identifying information (e.g., name of the child, medication dispensed, dosage prescribed, and expiration date).

Check if child self-medicates*_____(Insulin, inhalers, epipen). **If checked, this child has been properly trained to self medicate by this office.**
*The school will not be responsible for students who self-medicate.

_____ _____ _____
Physician Name Print/Stamp **Physician Signature** Date

_____

(**SCHOOL USE ONLY**)

Name and title of persons to administer medication (1)_____
(2)_____3)_____

Approved by_____ _____
Principal's Signature Date

Reviewed by_____ _____
School Nurse's Signature Date

Procedures for Medication Administration at School

Responsibilities of Parent/Guardian:

1. Complete a Henderson County Public Schools' Request for Medication Administration form at the beginning of each school year and/or when medication dosage has been changed. Provide physician signature for all prescription medication. Physician signature may be required for non-prescription medication at school nurses discretion.
2. Provide the medication in a pharmacy labeled container, including student's name, medication name, expiration date of medication, dosage and frequency of medication, directions for administration and physician's name. Non- prescription medications must be in the original container.
3. Provide new containers with new labels if dosage information changes.
4. Provide responsible adult to transport medication to and from school.
5. Provide responsible adult to count and document number of tablets of controlled medication (ex. Ritalin, Adderall, prescribed pain medication) with school personnel administering the medication.
6. Remove remaining medication from school premises when treatment is completed or medication is discontinued.

Responsibilities of Students:

1. Know and follow medication policy and procedures.
2. Never share medication with others.
3. Take prescribed medication as ordered by physician.

****Copy of both sides will be provided to parents/guardians**.