

# Physician's Authorization of Medication for a Student at School

The principal of: \_\_\_\_\_ Date: \_\_\_\_\_

Name of Student: \_\_\_\_\_ Birthdate: \_\_\_\_\_

*In order to keep this student in optimum health and to help maintain maximum school performance it is necessary that medication be given during school hours.*

Medication: \_\_\_\_\_ Color, if applicable: \_\_\_\_\_  
*Include trade name and prescription number*

Medication to be given in the form circled below:

Tablet                      Ointment                      Capsule                      Inhalation                      Liquid

Other: \_\_\_\_\_

Dosage (amount to be administered): \_\_\_\_\_

Relationship to meals: \_\_\_\_\_

How often and at what time: \_\_\_\_\_

Route of administration: \_\_\_\_\_

Concentration of medication: \_\_\_\_\_

If medication is on a PRN (as needed) schedule, describe how the person administering medication is to determine when the drug is needed: \_\_\_\_\_

Side effects (expected or predictable): \_\_\_\_\_

*No injection will be administered except in an extreme emergency such as allergy to wasp or bee sting or the like. Child's parent/guardian knows of this request and is in full agreement that this medication will be administered as needed. The parent/guardian agrees to supply the medication as needed. Should the student manifest any of the following symptoms caused by the medication, please discontinue administration and contact the parent or my office.*

Contraindication for Administration: \_\_\_\_\_

\_\_\_\_\_  
*Physician Signature*

\_\_\_\_\_  
*Telephone*

\_\_\_\_\_  
*Narcotic Number*

## Parent's Permission

I hereby give my permission for my child \_\_\_\_\_ to receive  
*Name of Student*  
\_\_\_\_\_ during school hours. I understand that the school  
*Name of Medication*

undertakes no responsibility for the administration of the medication. A licensed physician has prescribed this medication. I hereby release the School Board and their agents and employees from any and all liability that may result from my child taking the prescribed medication.

\_\_\_\_\_  
*Signature of Parent/Guardian*

\_\_\_\_\_  
*Telephone*

\_\_\_\_\_  
*Date*

## School Use Only

Name and Title of Person to Administer Drug: \_\_\_\_\_

Approved by \_\_\_\_\_ Reviewed by \_\_\_\_\_  
*Signature of Principal                      Date                      Signature Public Health Nurse/School Nurse*

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## Notification to all Parents of the Southmoreland School District

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### Policies and Procedures for the Administration Of Medication to Students in the Southmoreland School District

#### **1. Policy Concerning Prescription Drugs**

The basic position of the Southmoreland School District regarding administering medication during the school day is that it should be avoided if at all possible. If in order to maintain sufficient health to participate in the school program a procedure shall be adhered to:

- A. Requests from a parent or guardian for permission for their child to receive medication during school hours must be accompanied by written authorization signed by the parent or guardian. A physician's signature is required on the Physician's Authorization of Medication for a Student at School form, which details the name of the drug, dosage, and time interval for the medication that the student is to receive. Under no circumstances, are any drugs to be administered that have not been prescribed by a physician and with respect to which parental permission has not been obtained. Contraindications for administering of medicine must be clearly stated by the physician.
- B. The medication, which has been prescribed by the physician, must be brought to school in a container appropriately labeled by the pharmacy or by the physician.
- C. The persons(s) who have been designated for the administration of the medication to the student shall maintain records of the administration of the medication to the student as follows:
  1. The date and time when the medication is first administered to the student (and each subsequent administration) under the authorized agreement and the name of the drug, dosage and route.
  2. The date when the medication is discontinued.
  3. Medication, which is administered only "as needed", is to be recorded each time it is given. Record date, time and route of administration.
- D. More than one person may be responsible for medication administration. These persons will be designated by the principal to provide backup should the person designated be on vacation or sick leave.
- E. This form should be completed on all medications, prescriptions and non-prescriptions to be administered during the school day.

#### **2. Policy Concerning Non-prescription Drugs**

If it becomes necessary for a student to use non-prescription medication, such as aspirin, the student or parent(s) or guardian(s) will be completely responsible for its administration and will furnish a note of information to the school. No nurse or teacher will be required to dispense non-prescription medication unless the same procedures as applied to prescription medication are followed.