Marion I.S.D

Health Services Office

MEDICATION ADMINISTRATION FORM DURING SCHOOL HOURS

STUDENT: ______________________________ **BIRTHDATE:** ____________________

REASON FOR MEDICATION: ____

DATES TO BE GIVEN: ____

*****OVER THE COUNTER MEDICATIONS GIVEN LONGER THAN 5 CONSECUTIVE DAYS MUST HAVE PHYSICIAN SIGNATURE BELOW*****

MEDICATION REQUIREMENTS

***** ALL MEDICATIONS SHOULD BE GIVEN AT HOME IF AT ALL POSSIBLE*****

- MEDICATION (INCLUDING REFILLS) **MUST** BE DROPPED OFF BY A PARENT / GUARDIAN / ADULT DESIGNEE
- MEDICATION **MUST** BE DROPPED OFF IN ORIGINAL BOTTLE WITH PHARMACY PRESCRIPTION LABEL (WHEN APPLICABLE) ***ASK PHARMACY FOR AN EXTRA LABELED BOTTLE FOR MEDICATION GIVEN AT HOME & AT SCHOOL***
- MEDICATION **CANNOT** BE EXPIRED. EXPIRED MEDICATION **WILL NOT** BE GIVEN
- **PHARMACY LABEL MUST INCLUDE**: STUDENT NAME, NAME OF MEDICATION, DOSE TO BE GIVEN, TIME OF ADMINISTRATION, ANY OTHER SPECIAL INSTRUCTIONS
- PHARMACY LABEL **MUST** MATCH PHYSICIAN ORDER / INSTRUCTIONS
- **PARENTS ARE RESPONSIBLE** FOR KNOWING WHEN A CHILD'S REFILL IS DUE
- VITAMINS / HERBAL SUPPLEMENTS / ESSENTIAL OILS **WILL NOT** BE ADMINISTERED AT SCHOOL
- DISCONTINUED / LEFTOVER MEDICATION **MUST** BE PICKED UP BY A PARENT / GUARDIAN / ADULT DESIGNEE

MEDICATION	DOSE	TIME	ROUTE

In signing this form, I give permission for my child to receive medication during school hours. I understand the school takes no responsibility for the administration of the medication. I release the School Board and their agents and employees from any and all liability, which may result from my child taking this medication. I understand the district medication policy is available on the district website, and I can also request a copy from the school nurse.

______________________	______________________	______________________
PHYSICIAN SIGNATURE	**PHONE NUMBER**	**DATE**
______________________	______________________	______________________
PRINTED PHYSICIAN NAME	**PARENT SIGNATURE**	**PARENT PHONE NUMBER & EMAIL**