LANESVILLE COMMUNITY SCHOOLS

# Prescription Medication Authorization/Administration

Guidelines:

1. All medication, both prescription and non-prescription, to be used during the school day must be given to the school nurse or her designee at the start of the school day.
2. This form must accompany the medication and must be completed and signed by a parent/guardian and the healthcare provider (physician, dentist, or nurse practitioner).
3. A new form must be completed each new school year and each medication must be on its own form. 4. All medications must be kept in the original container, prescription medication must be in a pharmacy bottle labeled correctly with the dosage and times to give matching the physician's order on this form. The student's name must be on the bottle.
5. Any change in medication, dosage, or time to be given must be given in written form with the parent and health care provider's signature.
6. Medications are kept under lock and key and are dispensed by the school nurse or her designee unless the physician has ordered it to be self-administered.
7. Parents must pick up remaining medication within one week of termination of an order or within one week of the end of the school year or the medication will be destroyed in the presence of a witness.

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**Student:** _____ **Date of Birth** _____ TO

BE COMPLETED BY THE PHYSICIAN:

**Medication to be given**: _____

**Dosage to be given**: _____ **Time**

**of Day to be given**: _____ **Condition**

**being given for**: _____ **Start Date**:

_____ **Stop Date**: ( ) End of School Year ( ) Other _____

Special Instructions:

( ) For **Emergency Meds** (i.e. inhalers, epi-pens, glucose tablets, etc.). This medication is to be self-administered by the student. He/she has been instructed in how to self-administer the medication and *may carry the medication on his/her person*.

( ) This medication is to be self-administered by the student. He/she has been instructed in how to self-administer the medication. This medication will be *kept in the nursing office*.

Physicians Signature:_____Date: _____

Physician's Printed Name: _____

Physician's Phone Number: _____

Physician's Address/City/State/Zip_____

TO BE COMPLETED BY THE PARENT:

I request, authorize, and give permission for the above named student to receive medication during the school day as indicated. I authorize school personnel to exchange information regarding this medication with the healthcare provider listed above and/or the dispensing pharmacy.

Parent/Legal Guardian Signature: _____Date: _____

Each time medication is brought to the school the amount of medication brought in and who brought it in will be recorded.

| Date | Amount | By Whom | Date | Amount | By Whom |
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At the end of the school year a letter will be sent to the parent/guardian to pick up the medication. If it is not picked up by the date indicated on the letter the medication will be destroyed in the presence of a witness.

Date Letter Sent: _____ Date to be picked up by: _____
Date Picked Up: _____ Amount: _____ By Whom: _____
Signature of person taking medication: _____

( ) Medication destroyed. Date: _____

School Nurse: _____ Witness: _____