

Van Buren Community School District Medication Administration Permission Form

Administration of Medication to Students

1. Medication must be prescribed by a legal provider to be administered at school.
2. A prescriber's signature is required for prescription medication.
3. A parent or legal guardian must provide written authorization.
4. To maintain the safety of all students, a responsible adult will transport medication to & from the school.
5. The first dose of a medication should be given at home. With the exception of emergency relief medications (Ex:Epi-Pen)
6. Medication will be in the original container with proper label. Expired or improperly labeled medication will not be given.
7. This consent is only good for the current school year.

This form must be completed and returned to the health office before medication will be administered at school.

Student name _____ DOB: _____

Medication _____

Reason for medication _____

Medication dose and route _____

Time to give medication _____

On Late start days: _____ I will give medication at home _____ Please give medication at school

With early dismissal: _____ I would like medication given at school _____ Child will take medication at home

Physician/Prescriber name _____ Phone Number _____

Special instructions: _____

*** Physician/ Prescriber signature**

Date

It is necessary for my child to be given medication during school hours. I give my permission for the school nurse, or designee to administer the medication listed above. I agree that the student has experienced no previous side effects from the medication. I further understand that it may be in my child's best interest for the health staff to share this medication information with other school staff (teacher, counselor, etc. as necessary) and give permission to do so if needed. The school nurse has my permission to contact the prescribing physician if necessary.

Parent/Guardian name _____

***Signature** _____

Date _____ Home Phone _____

Work Phone _____

If there is unused medication at the end of the school year: (Please check one)

_____ I will pick up any unused medication at the end of the school year.

_____ Please discard any unused medication.

_____ Not applicable

***Parent/Guardian signature** _____ Date _____