U.S.D. 409 MEDICATION ADMINISTRATION FORM

Parents are asked not send medication to school if it can be given before or after school hours.

1. All medication must be in the original container and accompanied by written instructions from parent including dose, time and dates of administration at school, and reason for medication.
2. Over the counter medication will be administered according to written parent direction that is within the recommended guidelines of the manufacturer.
3. Prescription medication will be administered according to the directions of the pharmacy label. Any change in dose or administration must be accompanied by a new pharmacy label or a written or faxed order from the prescribing health care provider.
4. Prescription refills should be sent in prescription containers with the most recent refill date on the label.

NAME _____ GRADE _____ TEACHER _____

MEDICATION _____

DOSE TO BE GIVEN AT SCHOOL _____

TIME TO BE GIVEN AT SCHOOL _____

STARTING DATE _____ ENDING DATE _____

MEDICATION IS NEEDED FOR _____

(Initial each item)

_____My child is to take to above medication as directed. I request the school's cooperation in administering this medication..

_____I acknowledge that the school district and its officers, employees, or agents incur no liability for damage, injury, or death resulting directly or indirectly from the administration of medication and agreeing to release, indemnify, and hold the district and its officers, employees, and agents, harmless from and against any claims relating to the administration of medication allowed by policy JGFGBA.

_____I give the prescribing health care provider, doctor or pharmacist permission to discuss administration of the above medication with the school nurse.

PRINT NAME OF HEALTH PROVIDER _____

PRINT PARENT/GUARDIAN NAME _____

PARENT/GUARDIAN SIGNATURE _____

DATE _____

USD 409 Self-Administration of Medication

Name of student: _____

School: _____ Grade: _____

Teacher: _____

Medication: _____ Dosage: _____

Date started: _____ Ending date: _____

Conditions under which the medication is to be taken:

_____

Any additional circumstances under which the medication is to be taken:

_____

(Initial each item)

_____I hereby give my permission for _____(name of student) to administer the above medication at school as ordered.

_____I verify that my child

- knows the prescribed or recommended dosage,
- knows the time the medication is to be administered,
- knows for how long the medication is to be taken,
- and is able to articulate any additional special circumstances under which the medication is to be administered.

_____I understand that it is my responsibility to furnish this medication.

_____I acknowledge that the school district and its officers, employees, or agents incur no liability for damage, injury, or death resulting directly or indirectly from the self-administration of medication and agreeing to release, indemnify, and hold the district and its officers, employees, and agents, harmless from and against any claims relating to the self-administration of medication allowed by Policy JGFGBA.

_____My child has been instructed on self-administration of the medication, has demonstrated correct technique in the administration of the medication, and is authorized to do so in school.

_____ _____

Signature of Parent or Guardian Date

_____ _____

Signature of Health Care Provider Date