

MONONGALIA COUNTY SCHOOLS POLICY (9-21-E1)
MEDICATION FORM

School: _____

All medication (prescription or non-prescription) must be in the original container and properly labeled bearing the student's name (No exceptions!).

Student's name _____ Birthdate _____ Homeroom teacher/Grade _____ / _____

TO BE COMPLETED BY THE LICENSED PRESCRIBER ONLY

NON-PRESCRIPTION and PRESCRIPTION MEDICATION

Name of medication _____ Known drug allergies: _____

Reason for medication _____

***** If rectal Diastat/Diazepam is prescribed, may this medication be administered by unlicensed personnel? _____ Yes _____ No

***** May this student self-administer their emergency medication if permitted by the county policy? _____ Yes _____ No

***** May this student carry their emergency medication on him/her if permitted by county policy? _____ Yes _____ No

Dosage (amount to be given): _____ Date/Time medication to be given _____

I give permission for the above medication to be administered to my patient at school.

Licensed prescriber's SIGNATURE _____ Date _____

Licensed prescriber's PRINTED name _____

Licensed prescriber's address _____

Phone _____ Fax _____

If there are potentially serious side effects, please outline any necessary emergency response on a separate sheet.

TO BE COMPLETED BY THE PARENT/GUARDIAN ONLY

I understand that, whenever possible, all medications should be given at home. I give permission for my child: _____ to take the above medication at school according to the Monongalia County Schools Medication Policy. I also understand and agree that the school nurse may talk with the licensed prescriber and/or his/her staff, as well as school personnel, regarding the student's condition and administration of this medication and its effects. I also understand that this form must be completed and signed by a licensed prescriber and the parent/guardian for any medication to be given in the school setting and that a separate order is required for each medication and *orders are good for the current school year only*. I also understand that all medication changes (dosage, time, etc.) require the completion of another form.

Parent/Guardian (print name) _____ Date _____

Parent/Guardian (signature) _____

Cell phone _____ Work phone _____



REMINDER: Please read and sign back of form before returning to School Nurse

ATTENTION PARENT/GUARDIAN

In order to make administration of medications safe for staff and students, we ask that you adhere to the following guidelines:

1. Administration of medication is foremost the responsibility of the parent or guardian. All medications that can be given outside the school hours without serious effects must be given before and after school. Example, medication (i.e. antibiotics) that is to be given three times a day can be given at breakfast, after school, and at bed time unless otherwise indicated by a licensed prescriber.
2. If a dose of medication must be given during school hours, it can be administered at school as long as the following is in order:
 - a. Signed medication form by parent.
 - b. Signed medication form or prescription note by the licensed prescriber.
 - c. ALL MEDICATION must be in the original container/bottle and labeled with the child's name (no medication in baggies, boxes, etc.).
 - d. The first dose of a new medication must have been given by the parent/guardian at home in case of allergic reaction by child.
3. If any of the above medication guidelines in paragraph 2 regarding administration of medication during school hours has not been met, no medication will be administered to the student by school staff. These guidelines are directed by Monongalia County Schools Medication Policy and administration of any medication will become the responsibility of the parent until all the guidelines have been complied with.
4. Only send in enough medication to complete the required dosing administered at school (30 day supply is the limit). *AT NO TIME WILL MEDICATIONS WILL BE SENT HOME WITH THE STUDENT. IT WILL BE THE RESPONSIBILITY OF THE PARENT/GUARDIAN TO PICK UP ALL REMAINING PRESCRIPTION MEDICATION(S) AND/OR NON-PRESCRIPTION MEDICATION(S) FROM THE SCHOOL.*

I have read the above statements and will follow the procedures and guidelines regarding medication administration at school as set forth by the Monongalia County Schools Medication Policy.

Signature of Parent/Guardian
Parent Medication Letter

Date