REMINDER TO PARENTS:
ADMINISTRATION OF MEDICATIONS TO STUDENTS

1. No medications will be administered to a student without written permission from parent or guardian. A permission form must be signed and on file for each child who receives a medication at school.

2. New authorization is needed at the beginning of each school year.

3. According to school policy, medications administered at school will be limited to ingested medications unless specific care plans are on file and approved by an administrator or school nurse.

4. **All medications must be brought to school by parent or guardian.**

5. All medications must be in the original container. **School personnel will not administer unlabeled medications.**

6. The pharmacy or physician must appropriately label prescription medications.
This label must include: Child's name, doctor, medication and dosage.

7. No medications are to be kept with the student except those required for asthma or allergic reaction. Specific authorization forms must be filled out for Inhalers and EPI pens. These are available in your school office.

8. The parent or guardian must pick up unused medications. No medications will be stored over the summer. Remaining medications or contaminated medication will be disposed of properly at the conclusion of the school year.

If you have any questions or concerns, please feel free to contact me.

Andrea St. Charles R.N. B.S.N.
Rockford District Health Nurse
863-6031 ext. 7030

MEDICATION PERMISSION & ADMINISTRATION FORM
PRESCRIPTION / NON-PRESCRIPTION

Date _____**(Permission form expires at the end of the current school year)**

CHILD'S NAME _____ DATE OF BIRTH _____

ADDRESS _____ SCHOOL _____

PARENT'S NAME _____

HOME PHONE _____ WORK PHONE _____

DOCTOR'S NAME _____ OFFICE PHONE _____

NAME OF MEDICATION _____ Strength of Medication _____

DOSE: _____ (Number of tabs) EVERY _____ Hours (Number of hours)

TIME TO BE ADMINISTERED: ☐ SPECIFIC TIME _____

☐ AS NEEDED
☐ I wish to be notified when medication is given to my student.

NUMBER OF MEDS. RECEIVED _____

I hereby request and authorize school personnel to administer to my child the above medication as directed. Authorization includes permission for school personnel and Physician/health care provider to contact each other if needed.

SIGNED _____
(Parent or Guardian Signature)

AS 2016