

Potosi School District
Form A

updated 2016

**REQUEST FOR ADMINISTERING PRESCRIPTION MEDICATIONS OR
LONG TERM NON-PRESCRIPTION MEDICATIONS AT SCHOOL**

TO BE COMPLETED BY M.D.

*Name of Student _____

*Name of Medicine _____

*Reason for Medication _____

*Precautions, possible reactions, and/or interventions _____

*Dosage/Amount to be Given _____

*Time of Day to be Given _____

*Number of Days to be Given _____

*Duration - Short Term _____ or Long Term _____

*Name of Practitioner _____

*Signature of M.D. _____ Date _____

Medications must be in prescription bottle and labeled and kept in the school office for distribution. Parent/Guardian shall pick up unused portions of medication within 7 days after completion of the school year or when medication has been discontinued. After written/verbal communication medications will be destroyed.

I hereby allow my child to self-administer the above medication

Parent Signature _____ Date _____

Potosi School District Form B

NON-PRESCRIPTION MEDICATION

Student Name _____ **Grade** _____

I hereby give my permission to the school to give the medication to my child according to the directions stated below.

I further agree to hold the school and personnel giving medication harmless in any and all claims rising from the administration of this medication at school.

I agree to notify the school, in writing, when any change in the above order is necessary.

Any non-prescription medication intended for long term usage on a daily basis must be submitted on Form A.

Medications must be in original manufacturing packaging with ingredients recommended dose and with student's name affixed. The medication will be kept in the school office for distribution.

*Name of Medicine _____

*Reason for Medication _____

*Dosage _____

Date _____

Parent/Guardian Signature

Medications must be in original bottle and labeled with ingredients and recommended dose with the student's name. All medication must be supplied by the parent. Parent/Guardian shall pick up unused portions of medication within 7 days after completion of the school year or when medication has been discontinued. After written/verbal communication medications will be destroyed.

Potosi School District Form C

Request for Self-Administered Medication

- A. Students with asthma may possess and self-administer metered dose inhalers or dry powder inhalers for the purpose of preventing or alleviating the onset of asthmatic symptoms. The student must have the written approval of the student's physician and the written approval of the student's parent or guardian. A copy of this approval will be present in the student's school and maintained in the medical record.
- B. Student who need to self-administer prescription medications must have the written approval of the student's physician and the written approval of the student's parent or guardian. A copy of this approval will be present in the student's school and maintained in the medical record.
- C. Responsible students, as determined by the parent and school district representative, may possess and self-administer non-prescription medications for other than long-term use without practitioner approval.
- D. For non-prescription medication self-administration, a written statement identifying the medication and granting permission for self-administration of non-prescription medication must be signed by the parent/guardian. This statement should be maintained in the school's medication file.

The medical records related to self-administration are to be updated annually.

Factors to be considered for approval of student self-administration include:

- Reason for medication
- Age of student
- Responsibility of student
-

*Name of Medicine _____

*Reason for Medication _____

Student Name _____ Grade _____ Birthdate _____

Parent Signature _____ Date _____

Healthcare Professional signature _____ Date _____

*Required for self-administering of prescription meds or long term non-prescription meds.