 McKenzie Special School District

The medication administration policy of the school system states: medications shall be administered only when the student’s health requires that they be given during school hours. Medication must be brought to the school by a responsible adult, **not the student**. **Prescription** medication **must** have a **proper pharmacy label** attached. **Non-prescription** medication **must** be in the **original container** and **unopened**. All medication shall be kept in a locked cabinet. Inhalers may be kept with student if noted by physical below.

\*\*\*\*\*\*\*\*\*\*\*\*\*\*\*\*\*\*\*\*\*\*\*\*\*\*\*\*\*\*\*\*\*\*\*\*\*\*\*\*\*\*\*\*\*\*\*\*\*\*\*\*\*\*\*\*\*\*\*\*\*\*\*\*\*\*\*\*\*\*\*\*\*\*\*\*\*\*

TO BE COMPLETED BY PHYSICIAN OR AUTHORIZED PRESCRIBER

(OF NON-PRESCRIPTION MEDICATION, PARENT/GUARDIAN MUST FILL OUT)

Student Name \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Grade \_\_\_\_\_\_ Homeroom Teacher \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Name of medicine \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Reason for use \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Form of medicine/treatment:

Tablet/Capsule \_\_\_\_\_ Liquid \_\_\_\_\_\_ Inhaler \_\_\_\_\_\_ Nebulizer \_\_\_\_\_ Other \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Schedule (time to be given at school) \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Dosage: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Restrictions and/or important side effects: NO \_\_\_\_\_ none anticipated

YES \_\_\_\_ please describe \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Special Storage requirements: None \_\_\_\_\_ Refrigerate\_\_\_\_\_\_\_\_ Other \_\_\_\_\_\_\_

This student is both capable and responsible for self-administering this medication: No \_\_\_\_

Yes, with supervision \_\_\_\_\_

Student may carry this medication. (EMERGENCY MEDS ONLY) \_\_\_\_\_

Date: \_\_\_\_\_\_\_\_\_\_\_\_\_\_ **Physician signature**: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Physician name: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Phone number: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Address: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

\*\*\*\*\*\*\*\*\*\*\*\*\*\*\*\*\*\*\*\*\*\*\*\*\*\*\*\*\*\*\*\*\*\*\*\*\*\*\*\*\*\*\*\*\*\*\*\*\*\*\*\*\*\*\*\*\*\*\*\*\*\*\*\*\*\*\*\*\*\*\*\*\*\*\*\*\*\*\*\*\*\*\*\*\*

**To be completed by parent/guardian:**

I give my permission for my child to receive the above medication during the school day assisted by school personnel as necessary. My child is both capable and responsible to self-administer this medication **with assistance**. YES\_\_\_\_\_\_\_ NO\_\_\_\_\_\_\_

**Parent/Guardian Signature**: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Date: \_\_\_\_\_\_\_\_\_\_\_\_\_ Phone Number: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_