Dorchester School District 4

DOCTORS' ORDERS

Medication Procedure Both

Student Name _____ DOB _____

School _____ Grade _____ Teacher _____

****

Medication/Procedure _____

Dosage/Specifics _____

Purpose of Medication/Procedure _____

Time of day medication/procedure is to be given: _____

Please indicate where the morning dose will be given: _____Home _____School

Possible side effects: _____

Anticipated number of days medication needs to be given at school: _____

Known Allergies: _____

STATE REQUIREMENT: DOCTOR MUST SIGN THIS FORM BEFORE ANY MEDS ARE GIVEN AT SCHOOL

ICD10 CODE: _____

Physician Name (print) _____

_____

Full Address of Physician's Office and Phone Number with Area Code

_____

SIGNATURE OF LEGAL PRESCRIBER Date

PARENT /GUARDIAN MUST SIGN BELOW:

As the parent/guardian I, the undersigned, ask that the above medication/procedure be administered to my child as directed and hereby release everyone participating in this request from any and all liability associated therewith or stemming therefrom. When the school nurse is not available, the school's trained designee will assist your child. A parent or responsible adult, NOT THE STUDENT, must bring in all medications.

I hereby give my permission for my child _____to follow the above Prescription at school as ordered. I understand that it is my responsibility to furnish this medication and the container will be labeled with the name of the student, the name of the medication, amount to be given, time of day to be given, and physician's name, if prescribed medication. I understand that nonprescription medication must be in the original container. When changes are made in medication, dosage or time, a statement from the prescribing doctor must be provided to the school before this change is made at school. I understand that school officials cannot be held liable for adverse effects from this medication. Parents are responsible for medication until it is received by the nurse or other designated school personnel.

Parent/Guardian Signature _____ **Date** _____

Parent/Guardian Phone Numbers:

Home: _____ **Cell:** _____

Work: _____ **Other:** _____

Medication Amount received: _____ Nurse Signature _____

Dorchester School District 4

Guidelines for Medications and Procedures in the School Setting

1. Medications are to be brought to the school by a parent/guardian. All CONTROLLED medications are counted in the presence of the parent/ guardian and the parent/guardian must sign acknowledging that the count is correct. Medications are not to be sent by students and will not be sent home by students. Students will also be required to sign for medications every time they are administered to the student.

2. Any prescription or over-the-counter medication brought to school by the parent must be in its original container and labeled with the student's name.

3. Written permission is required from the parent and the doctor prescribing the medication/procedure. Over-the-counter medications also require a doctor's order. The school permission for medication form will be completed by the parent and also requires the doctor's signature that prescribed the medication. A copy of the prescription may also be accepted.

4. When changes are made in procedure requirements, medication, dosage, or time, a statement from the prescribing doctor must be provided to the school before this change is made at school.

5. The first dose of a medication that a student has not taken before should be given by the parent/guardian at home so that the student can be monitored closely for side effects.

6. Medication/procedure permission forms and orders must be updated at the beginning of each new school year and when changes are made to the student's medication/procedures.

7. Medications should be picked up by the parent/guardian at the end of the school year. Medications left at school will be discarded.