Dubuque COMMUNITY SCHOOLS

MEDICATION ADMINISTRATION PERMISSION FORM

PRESCRIPTION AND OVER-THE-COUNTER

STUDENT INFORMATION

STUDENT NAME:	DATE OF BIRTH (mm/dd/yyyy):

PRESCRIBER AUTHORIZATION OF MEDICATION

PRESCRIBER NAME:

REQUEST FOR MEDICATION: [ ] CLINIC TEMPLATED REQUEST FOR MEDICATION ORDER ATTACHED *If no, please complete the following:*

MEDICATION:	DOSAGE:	ROUTE:	TIME:

LENGTH OF TIME MEDICATION WILL BE REQUIRED: [ ] SCHOOL YEAR *Please specify (e.g. 24-25):* [ ] OTHER *Please specify:*

DIAGNOSIS:	ICD-10 CODE:

ADMINISTRATION INSTRUCTIONS:

PRESCRIBER'S SIGNATURE _____ DATE _____

PARENT/GUARDIAN AUTHORIZATION OF MEDICATION

PARENT/GUARDIAN NAME:

SHOULD MEDICATION BE GIVEN ON ALTERNATE SCHEDULE DAYS? *Check only those that apply.* [ ] ONE-HOUR LATE START [ ] TWO-HOUR DELAY [ ] EARLY DISMISSAL

DISPOSAL OF UNUSED MEDICATION:

[ ] I WILL PICK UP ANY UNUSED MEDICATION AT THE END OF THE SCHOOL YEAR.
NOTE: if medication is not picked up by the last day of school, the medication will be disposed of per district procedure.

[ ] PLEASE SEND ANY UNUSED MEDICATION HOME WITH MY STUDENT.
NOTE: The school district will not be responsible for the medication once it is in the possession of my student.

[ ] PLEASE DISCARD ANY UNUSED MEDICATION.

I request that the above medication be given to the above student by the school nurse and/or qualified personnel.

In the event of an emergency, I give the school nurse and/or legal prescriber permission to communicate with one another regarding this medication and medical condition or if there are questions about the medication.

I have read School Board Policy #7200 and acknowledge that medication must be provided to the school in the original, labeled container, either as dispensed or in the manufacturer's container. I understand that medication will not be given if expired or has an improper label. I also understand that the time of medication may need to be altered slightly to fit your student's schedule.

I understand that only a month supply of medication should be provided to the school and it is the responsibility of the parent/guardian to provide any necessary supplies required for medication administration (e.g. syringes or droppers for liquid medications, soft food or juice to aid with swallowing solid medications, etc.). Supplies must be provided with the medication and be clearly labeled with the student's name.

By signing I represent and confirm that I am the student's lawful parent/guardian or that I have been given valid legal authority to act in the place of a parent/guardian and understand that the school district shall not be responsible for any misrepresentation of this legal status.

PARENT / GUARDIAN SIGNATURE _____ DATE _____

» PLEASE RETURN SIGNED FORM TO THE SCHOOL HEALTH OFFICE.

NOTE: This completed form must be on file at the student's school before any medication will be given.