EASTERN HANCOCK COMMUNITY SCHOOL CORPORATION
REQUEST AND AUTHORIZATION TO ADMINISTER PRESCRIPTION MEDICATION

All spaces must be complete before medication will be administered at school. This is a two page form.

Dear Parent/Legal Guardian and Health Care Provider:

-You and your child's prescribing health care provider must complete this form in its entirety. Each medication requires its own form to be completed.
-This form is valid for the current school year only.
-A new form is required for any changes in medication, dose, or administration time.
-The health assistant must be notified in writing when a medication is to be discontinued.
-All medication must be brought to school by a parent/guardian, or an adult, age 18 and over, who is on the student's emergency contact list in Skyward.
-Medication brought to school by a student will not be given and a parent/guardian must come to the school to retrieve the medication.
-Up to a 60 day supply of medication will be stored in the clinic. The adult that brings the medication to school will count in medication with clinic personnel. Medication should be brought to the clinic during regular school hours.
-Medication containers must be labeled by the pharmacy with the student's name, health care provider's name, name of medication, dosage, route (i.e., by mouth), conditions for storage, prescription date and expiration date. ***The information on the prescription label must match the health care provider-supplied documentation provided on this form.***
-Clinic personnel will discard empty prescription bottles. The prescription label will be removed and shredded by clinic personnel.
-Medication will not be returned home with students. A parent/guardian or an adult, age 18 and over, who is on the student's emergency contact list in Skyward, must pick up the medication from the clinic.
-Medication not picked up by the end of the day on the last day of school will be destroyed. Expired medications will also be destroyed. In the event a medication is discontinued, the medication must be picked up by the parent/guardian within five school days or the medication will be destroyed.
-Personnel administering medication are trained on safe medication administration practices on an annual basis. These trained but unlicensed personnel will most likely give medication. A list of trained personnel is on file with the corporation nurse.
-Medications can be administered up to 60 minutes prior to or 60 minutes after the scheduled administration time. Health assistants will make a good faith effort to administer medication as scheduled. Should your student arrive at the clinic outside of this time period, the dose will not be given.
-The parent/guardian should provide any consumables necessary for medication administration (disposable cups, syringes, spoons, applesauce, pudding, snacks, etc.).
-Medication stored in the clinic is only available to the student during the regular school day.
-Medications that are deemed necessary to be to be carried with a student (i.e. inhalers) can be carried with them as physician permission is included on this form. Antibiotics prescribed three times per day need to be administered before school, after school and at bedtime.

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To Be Completed by Prescribing Health Care Provider

Name of Student: _____ Date of Birth: _____ Grade: _____

Medication Name and Strength: _____Dose:_____Route:_____

Condition for which medication is being prescribed:

_____

Time of day dose is to be administered at school (Parent/guardian must give the morning dose at home. School personnel will not administer AM doses.): _____

If medication is to be given "as needed", please list frequency (i.e., "every 4 hours"): _____

If "as needed", please list specific symptoms requiring medication:

_____

Start Date of Medication: _____ Stop Date (dose will be given on the date specified, but not after):_____

Side Effects:

_____

Prescriber's Printed Name and Title: _____Telephone: _____

Address: _____Fax: _____

Prescriber's Signature: _____Date: _____

To Be Completed by Parent/Guardian

I request that school personnel administer medication as prescribed by the health care provider. I certify that I have legal authority to
consent to medical treatment for the student named above, including the administration of medication at school.
I authorize the principal, health assistant and school corporation nurse to communicate with the prescribing health care provider regarding this student's medical condition.
I give permission for my student's medical information to be shared with teachers and other school personnel.
I agree to abide by the guidelines regarding prescription medication administration at school. I will provide any supplies necessary for my student to take this medication as prescribed, including cups, syringes, spoons, applesauce, crackers, etc.

Parent/Guardian's Printed Name: _____

Cell Phone Number: _____Work Number: _____

Home Number: _____ Email Address: _____

Parent/Guardian's Signature: _____Date: _____