



MEDICATION ADMINISTRATION AUTHORIZATION

PARENT/GUARDIAN REQUEST FOR MEDICATION TO BE ADMINISTERED TO STUDENT WHILE AT SCHOOL

MEDICATION GIVEN TO STUDENTS AT SCHOOL

Medications will be given during school hours only when absolutely necessary. We encourage dosage schedules which allow medicine to be taken at home before and after school. When this is not possible, Health Services personnel will follow the guidelines stated below when administering medication to your child at school. On occasion, someone other than the school nurse may dispense medication to your child (i.e., during field trips, lunch periods, etc.). These personnel will be trained and guided by a nurse.

MEDICATION GUIDELINES

1. The Medication Authorization Form must be completed and signed by the parent/guardian for all medications given at school.
2. All Prescription medication must have the label attached by the pharmacist/physician.
3. All non-prescription "over the counter" medication must be sent in the original container. The child's name must be on the medication container. Only the instructions listed on the medication container will be followed unless a physician requests (in writing) different instructions for administering the medication.
4. Any change in the time or dosage of medications must be accompanied by a written request from the physician. A new pharmacy label is preferred.
5. No expired medications will be dispensed.
6. It is recommended that only enough medicine for one (1) week or less be brought to school for "as needed" prescription medications. Up to a thirty (30) day supply will be accepted for scheduled daily medications.
7. Health Services personnel will work with the student, parents, and teacher to encourage student responsibility to come regularly to the health office for scheduled medication.
8. Medications may NOT be sent with children on the bus. Parents/guardians must bring medication to the health office at school, and then pick up unused medication at the end of the school year, or when the physician's order expires.

Student Name:	Date of Birth:	Grade/Teacher:
Name of Medication:	Dosage:	Time to be given at school:
Diagnosis or Condition:	Special instructions:	

Please Initial:

- _____ I have read and understood the medication guidelines above.
- _____ I understand that I may cancel this request and retrieve the medication/supplies from school at any time.
- _____ I give the school nurse permission to contact my child's physician/pharmacist directly by verbal or written communication to provide information on my child's condition or to clarify medication administration instructions.
- _____ I understand it is my responsibility to provide the school with an adequate supply of medication/supplies needed for my child's health condition, and will inform the school immediately of any change in these orders.
- _____ I understand that medications/supplies will be disposed of if not picked up within one week of termination of the order or upon the last day of school, in accordance with the Kearney School District Policies and Procedures.

Parent/Guardian Signature _____ Date _____



Prescription Medication Transaction Form

Parent/Guardian must count controlled medication
with Nurse upon drop off and pick up

Student Name: _____ Medication: _____ Dose: _____

Date	Time	Quantity on Hand	Quantity Provided	Updated Quantity	Nurse Signature	Parent/Guardian Signature

- Medication picked up by Parent/Guardian** Date: _____ Time: _____ Quantity: _____
 Nurse Signature: _____ Parent/Guardian Signature: _____
- Medication discarded with Witness** Date: _____ Time: _____ Quantity: _____
 Nurse Signature: _____ Witness Signature: _____