Cocalico School District Health Services
Medication Administration Permission Form

The Cocalico School District recognizes that to insure good health and best educational conditions, it is sometimes necessary for pupils to receive medication during school hours. **School district policy limits the administration of medications in school to only those absolutely necessary.** Whenever possible, medication should be given to students at home, before or after school. If medication is to be given during school hours, the following procedures must be used:

- The medication, in its original container, labeled by a pharmacist or a physician with medication name and dosage information must be accompanied by this completed and **signed** permission slip from the parent or guardian**.**
- ***All*** over the counter medications require a physician's prescribing information to be administered in school.
- Elementary students are not permitted to transport medication to school. Secondary students may transport medication to school, but it must be delivered to the health room immediately upon arrival. Any medication which comes under the law of controlled substances (such as Ritalin, Adderall) ***must be delivered by the parent*** to the school nurse, including secondary.
- All medications must be in the original containers. Prescription medications should be in the most recently labeled bottles. **Please DO NOT send unlabeled containers or medications to school.** All medications are kept in the nurse's office.
- Students are expected to come to the health room at the appropriate time to take their medication. Students who need to self-administer medications (such as inhalers) are permitted to do so with the school nurse's permission and written permission by a parent/guardian ***and*** physician. Students are required to report each self-administered dose to the school nurse when taken during regular school hours. (See asthma self-admin statements below*)

If you have any questions regarding medication administration, please phone your child's school health room.

I hereby grant permission for the nurse, or any person authorized by the school, to administer the medication listed below. If a medical necessity arises, the nurse may contact the prescribing professional to discuss this medication.

Name of Child _____ Grade _____ Teacher _____

Name of Medication _____

Reason for Medication _____

Possible Side Effects _____

Time to be given _____ Amount to be given _____

Duration of Order _____

Signatures required below for *any and all* medications to be administered during school hours.

***(Inhaler Statement)**As the parent/guardian, by circling yes below, I give permission for my child to carry and self-administer his/her **asthma inhaler**. I agree that my child will demonstrate to the school nurse the proper use and technique for carrying and self-administering this medication and will notify the nurse after any dose is taken. I also acknowledge that the school bears no responsibility for ensuring that the medication is taken or properly self-administered, and understand that neither the district nor any of its employees or designees shall be held liable for any injury resulting from self-administration. I agree that if my child abuses or ignores this privilege, school personnel may confiscate the asthma inhaler and the district will remove my child's privileges to carry the medication.

_____ _____ Student may self administer (inhalers only) **yes no**
Date **Signature of Parent required for all medication administration**

*(**Inhaler Statement**)As the health care provider for this student, circling yes below verifies that he/she has been taught proper use of his/her **asthma inhaler**, has adequate knowledge of asthma and how to control it, and is thought to be responsible enough to carry his/her inhaler and use it properly without supervision.

_____ _____ Student may self administer (inhalers only) **yes no**
Date **Signature of Physician required for all medication administration**
(Physician signature and instructions are required in order to carry and self/administer medication such as inhaler or Epi-pen)

For Health Room Use Only

Signature/Initials:

_____

_____

_____

_____

Date:	Date:	Date:	Date:	Date:	Date:
Date:	Date:	Date:	Date:	Date:	Date:

Coc 8/05 In computer: ❑ student computer record (prescription ordered)