Cedar Rapids Community School District

CEDAR RAPIDS COMMUNITY SCHOOL DISTRICT
MEDICATION ADMINISTRATION PERMISSION FORM
Administration of Medication to Students

Only medication prescribed by a legal prescriber* will be administered during the time the student is at school. A legal prescriber's signature is required for administration of any non-prescription medication, including natural remedies and supplements**. The parent or legal guardian will provide written authorization. The school will have the right to contact the prescriber's office to confirm or clarify medication instructions. All medication will be supplied to the school in the original container, properly labeled, and will be administered only by the school nurse or other personnel who have successfully completed a medication administration course conducted by a registered nurse or licensed pharmacist. Students who have demonstrated competence in administering their own medications may self-administer their medication with approval of the parent/guardian and of the school nurse. By law, students with asthma or other airway constricting diseases may self-administer their medication with approval of their parents and prescribing physician regardless of competency. A written medication administration record will be on file at school and retained for five years. All medication will be stored in a secure area unless an alternate provision is documented. Medication records will be kept confidential

***Legal Prescriber – physician, dentist, podiatrist, licensed physician assistant, advanced registered nurse practitioner.**

**Middle and High School students, in accordance with Health Services protocols for common complaints of pain, may have limited, over-the-counter medication with written parental consent.

- Non-prescription medication includes all over the counter products, like cough syrup, cough drops, enzymes, supplements.
- The medication must be kept in the Health Office unless the school nurse authorizes otherwise.
- Prescription container labels must include the following information: name of medication, strength and quantity, dosage, prescription serial number, name and address of pharmacy, date prescription is dispensed, time to be given, name of doctor, name of student, and route of administration.
- The time of medication administration may need to be altered slightly to fit your child's schedule. Please remind your child that she/he is responsible to go to the Health Office at the appropriate time.

This form must be completed and returned to the school Health Office for your child to have prescribed medication administered at school.

Name of Student: _____ School: _____ Grade: _____

Name of Medication: _____ Dosage: _____

Prescriber's Name: _____ Prescriber's Signature: _____
(Required for over the counter medications)

Approximate time to be given at school: _____

Give medication on late start days: _____ TIME

Give medication on early dismissal days: _____ TIME

Length of time medication to be given (if known): _____

Health condition for which medication must be given at school: _____

I request the above student be given this medication at school. The student has experienced no previous side effects from the medication. I further agree that school personnel may contact the prescriber as needed and that medication information may be shared with school personnel who need to know to provide appropriate services to this student.

_____	_____	_____
Parent/Legal Guardian	**Date**	**School Nurse**

If your child is on medication for behavior/attention concerns, you must also sign the Release of Information section below to give your approval for behavior checklists to be submitted to your healthcare provider.

RELEASE OF INFORMATION

I give my permission for exchange of information between school and _____
(Health Care Provider/Facility)

to be of assistance in the medical evaluation of above student for the duration of this school year.

My signature authorizes release of information relating to ☐ **mental health** ☐ **substance abuse** ☐ **HIV/AIDS**

_____	_____
Parent/Legal Guardian Signature	**Date**

Revised March 2014