GreatHearts
Irving

Request for Administering Prescribed Medications by School Personnel

STUDENT NAME.______________________ STUDENT#____________ BIRTHDATE.__________

SCHOOL ______________________ TEACHER______________________

NAME OF MEDICATION,______________________ Exp. Date______________

PHARMACY NAME & PRESCRIPTION NUMBER______________________

DOSAGE_______________________________

TIME TO BE GIVEN AT SCHOOL (DURING SCHOOL HOURS)______________________

DATE MEDICATION STARTS.______________ DATE MEDICATION ENDS______________

Reason for giving medication: -------------------------------

____

1. Written authorization is required to ***discontinue*** prescription medication.
2. Prescription Inhalant medication may be carried by the student only if directed in writing by the Physician and Parent. (Complete form for Asthma Inhalers at School)
3. Medication will be dispensed during school hours only.

Parent Consent: I consent to and authorize the health care provider to disclose health Information to the school, and for the school to disclose the above information to those within the school district who have a need to know for legitimate educational purposes.

Medications will be dispensed during school hours only.

Home Phone No.______________ PARENT/LEGAL GUARDIAN SIGNATURE______________

Work Phone No.______________

____
DATE

NOTE: PLEASE INDICATE BELOW YOUR PREFERENCE FOR DISPOSITION OF ANY UN-USED PORTION OF YOUR CHILD'S MEDICATION

______PARENT WILL PICK UP MEDICATION
______SEND MEDICATION HOME WITH STUDENT

Office Use

Date Medication Received | Quantity received | Initial & Date ______________

Refill date: ________	Quantity received:______	Received by________from:______________
Refill date: ________	Quantity received:______	Receivedby________from:______________
Refill date: ________	Quantity received:______	Received by.________from:______________
Sent Home date: ________	Quantity sent: ________	Sent home with: ______________

Request for Administering Over-The-Counter Medications by School Personnel

Student's Name:________________________________Date of Birth:___________

Known Diagnosed Allergies:____

Current Medications:____

Significant Medical History (Seizures, Heart Problem, Diabetes, etc.):

____

____

NAME OF OTC Medication to be given: ______________________________

- Medication must be in the original unopened container labeled with the student name.
- Labels on over-the-counter medications must designate contents as MEDICATION.

Reason for Giving:____

Dosage:______________________________

****Dosage must be within the recommended amount as stated on label.

Time to be given: _______________ Start Date:___________ Stop Date: _______

****Medications are given during school hours only.

A physician written request is required if medication is to be given more than five (5) consecutive school days.

Home Phone_________________ ________________________________

Parent's Signature

Work Phone _________________ ________________________________

Date

NOTE: PLEASE INDICATE BELOW YOUR PREFERENCE REGARDING ANY UN-USED PORTION OF YOUR CHILD'S MEDICATION.

_______Parent will pick up medication.

_______Send medication home with student.

Date Medication Received_______ Date sent home or picked up by parent: ______________

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MEDICATION POLICY

All medication must be brought to the Nurse's Clinic where it will be kept in a locked container or cabinet. Students may not possess any form of medication while at school other than while bringing it to the Nurse Clinic. Medication will be refrigerated only if refrigeration is required by the medication's labeling. At the end of the school year, all medication left at school will be returned to the parent or destroyed.

PRESCRIPTION MEDICATION

A designated Great Hearts employee may administer medication to a student provided:

1. Great Hearts has received a **written request** to administer the medication from a parent, legal guardian, or other person having legal control of the student.

2. Prescription medications must be in English & the original container, bearing **a prescription label** that includes the student's name, the name of the medicine, directions concerning dosage, the name of the prescribing physician, the name of the pharmacy filling the prescription, and the date the prescription was filled.

3. Prescription **inhalant medications, properly labeled, may be carried by the student only if directed in writing by the physician and parent.** This request must be filed in the Nurse Clinic. **Please request the appropriate form** from the school nurse.

4. All physician's sample medication must be accompanied by a written authorization from the physician.

No Great Hearts employee will be required to give medication above the daily recommended dosage by the Federal Drug Administration (FDA).

No medication will be dispensed for a missed dose unless written authorization is received from the parent or legal guardian for each dose missed.

OVER-THE-COUNTER MEDICATION

Designated Great Hearts employees may administer over-the-counter medications to students if the following conditions are met:

1. Great Hearts has received a **written request** to administer the medication from a parent, a legal guardian, or other person having legal control of the student.

2. The written request of the parent/guardian must indicate the dosage, frequency of need, the reason the medication is needed, and the date(s) of requested administration.

3. The medication must be stored in the original container. Dosage must be within the recommended amount for the weight of the student. **Medication may not be given for longer than 5 consecutive school days** unless directed by a physician.

The student will report to the Nurse Clinic to take any medication. Exceptions to the Nurse Clinic being the location for administering medications may be made if such is recommended by an ARD committee.

As a precaution to prevent tampering of the contents of an OTC medication, it must brought by a student to the Nurse Clinic in the original unopened container.