GREENFIELD-CENTRAL COMMUNITY SCHOOL CORPORATION

OVER THE COUNTER MEDICATION

REQUEST AND AUTHORIZATION TO ADMINISTER - 2018-2019 SCHOOL YEAR

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 for over the counter medications. 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 PowerSchool.
- Medication brought to school by a student will not be given and a parent/guardian must come to the school to retrieve the medication.
- ***Medication must be brought to the clinic in a new, sealed, unopened container.***
- 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 PowerSchool, 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 prescribed by the health care provider. 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. Some families find that a wristwatch with an alarm helps remind students to go to the clinic for their medication.
- Your student may be subject to video surveillance while in the clinic receiving medication.
- 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.
- In the event of a two-hour delay, medications will be given at the prescribed time. Doses will not be rescheduled.

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To Be Completed by Prescribing Health Care Provider

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

Medication Name: _____ 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 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: _____