West Central School District 49-7

Hartford-Humboldt, SD

Request and Authorization for Medication in School

This form is a requirement of the West Central School District. For **prescription medications**, both Parent and Physician must complete and sign the form before medication(s) can be given. For **over-the-counter medication(s)**, a Parent/Guardian must complete the form and sign before medication(s) may be given at school. Medication must be delivered directly to school nurse or administrative assistant by the Parent/Guardian or responsible adult, and it must be in an original pharmacy container or original manufacturer's container. You may request an additional labeled container from your pharmacist when filling the prescription.

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To be completed by Parent/Guardian and/or Physician

Date: _____ School: _____

Student's Name: _____ DOB: _____

Grade: _____ Teacher: _____ Bus: ☐ Yes or ☐ No

Parent/Guardian Name: _____ Phone#: _____

Name of Medication: _____ Dosage/Amount Prescribed: _____

Amount and time(s) to be administered at school: _____

Diagnosis: _____ Allergies: _____

If this is an emergency medication, i.e. inhaler, EpiPen, etc., has student been instructed to self-administer and may he/she do so? YES: ☐ _____ NO: ☐ _____

Physician's Name (prescription only): _____ Phone #: _____

Physician's Signature: _____ Date: _____

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To be completed by Parent/Guardian (initial appropriate option)

Option I: _____ (initial) I request and authorize the school nurse or trained personnel at the above named school to store and administer the medication prescribed on this form to my child. I understand the medication must be provided in a bottle, identifying the name and telephone of the pharmacy, the patient's name, physician's name and dosage of drug to be taken (if prescription), or in the original bottle (if over-the-counter). I understand the school and the individuals involved will not be held liable for any adverse effects of the medication. I give permission for communication that may be necessary between the prescribing physician and the school nurse to ensure safe medication administration for my child. In the event of a school sponsored field trip, I understand that my child's medication will be sent with designated personnel in the amount to be administered during the activity unless otherwise specified by me. In addition, I understand I am responsible to pick up unused medication when my child is finished or within one week of the last day of school. If medication is not picked up within one week after school is out, it will be destroyed.

Option II: _____ (initial) I request and authorize my child to keep and self-administer his/her own medication at school. I relieve the school district and personnel of all responsibility associated with this self-administration. I understand this option is available only when it will not be a potential health risk to my child or others. I understand that I have checked with the school nurse and have received approval for the over-the-counter medication my child takes be kept with my child. Except for inhalers and EpiPens, my child is to only bring enough medication for 1 day to school.

Parent/Guardian Signature: _____ Date: _____

Nurse's Signature: _____ Date: _____