

Parent Permission and Consent - Administration of Medications to Students

Please NOTE: Moberly Schools DOES NOT supply EPINEPHRINE for emergency treatment of Anaphylaxis.

Parent/Guardian – Please Print

Student's Name	Age	Grade	Date Of Birth	Homeroom/Teacher/Team

Medication/Prescription Information Prescription Medication Over-the-counter Medication

(Please complete one form for each medication to be given at school)

Name of Medication: _____ DOSE _____ ROUTE: PO /INH /INJ / EYE / EAR

Time to be given at school _____ Diagnosis for taking Medication: _____

PRN (as needed medication) Indicate conditions under which medication should be given: _____

Start/Stop/Restrictions/Requirements

START: Date form received Emergency events only Other, specify: _____

STOP: End of school year End of prescription (date) _____ Other, specify: _____

Please list conditions or adverse reactions indicating parental and/or physician notification _____

Additional information included: NO Yes attached paper(s)

Physician Information – must be completed for all prescription medications

Physician's Name: _____ Phone: () _____

Address: _____ Fax: _____

Parent/Guardian Request and Consent

I give permission for _____ (student's name) to receive the above medication at school. I also give permission for the school nurse to contact the student's physician by phone or fax when concerns about the student's medication or condition arise. I understand that the school nurse will inform other school personnel when needed and that only those school personnel with a need to know will be informed. I understand that I have the ultimate responsibility for providing the school with an adequate supply of medication and to inform the school nurse immediately in writing when a change in the above order is made.

School Board Policy and Safe Administration Standards

I understand that the medication must be transported to school by an adult for my child and must be in the **original** container for over-the-counter medications and in a **pharmacy bottle/bubble pack with a current date** for all prescription medications. I understand that this permission is for the current school year only. I understand that the School Nurse must review this request prior to administering the first dose of this medication at school. I understand that the school nurse will notify me through phone contact and in writing if this request is denied or revoked. I understand that the first dose of any new medication cannot be administered at school. I understand that medication(s) remaining after the prescription end date or after the last day of school must be destroyed (equipment will be stored in the nurse's office).

Parent/Guardian Signature: _____ Phone: _____ Date: _____

Emergency Contact Name: _____ Phone: _____

Return completed form with medication to the school.

School use only

School	Date received	Pharmacy	Script RX #	First dose given at home on	Notify parent/guardian	Entered SIS
				Date: _____	_____ days before out	