Dripping Springs High School

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MEDICATION ADMINISTRATION REQUEST

When it is necessary for your child to receive medication during the school day (*please see the Student Handbook for guidelines*), the following procedures **MUST** be followed:

1) Parents/Guardians must provide all medication, and parent/guardian signature is required for all medications given at school. **A licensed US physician's signature is required for all controlled substances, (i.e. most ADHD medications, narcotic pain meds) and for all medications prescribed differently from manufacturer's directions.**
2) All medications must be in the original container, clearly labeled with the student's name, the medication, dosage and directions for administration. **All controlled substances must be hand delivered to the school nurse by the parent/guardian or their representative over 21 yrs. of age.**
3) This medication request must be completed each school year *and* when there are any changes made to the original request including, but not limited to, medication and/or dose change. A separate form must be completed for each medication.
4) **Only FDA approved pharmaceuticals (prescription and non-prescription)** will be administered. No homeopathic, herbals, home remedies or dietary supplements will be accepted or administered by school personnel.
5) Parents/Guardians are strongly encouraged to pick up all medication after it is discontinued. **AT THE END OF THE SCHOOL YEAR, ALL UNCLAIMED MEDICATION WILL BE DESTROYED.**

TO BE COMPLETED BY PARENT/GUARDIAN

I, ________________________, request and give my permission for school personnel at ________________ to give my child, ______________________________, the following medication according to the stated directions. I understand and agree that the school will not be held responsible for any ill effects which might occur in connection with the administration of this medication.

Medication ________________________ Dosage ________________ Diagnosis/Reason__________________

Drug Allergies ______________________________ Side Effects/Precautions____________________________

Dates to be given: From___________________ To_____________________

Parent/Guardian Signature: ____ Date _____________

Relationship ___________________________________ Best Phone Number __________________________

PHYSICIAN ORDERS FOR MEDICATION

MEDICATION ______________________________ DOSE _______________________ ROUTE____________

TIME TO GIVE AT SCHOOL ___________________ SPECIAL INSTRUCTIONS:___________________________

DIAGNOSIS/REASON TO GIVE: ____

START: Date form received: _____ (check here) END: End of School year: _____ (Check here)

Other, as specified: _________________________ Other, as specified:_____________________

PHYSICIAN SIGNATURE: _______________________________________ **DATE:** _________________________

PHYSICIAN NAME: ____ PHONE: _________________________