USD 411 – Goessel Public Schools Health Services

REQUEST FOR PRESCRIPTION MEDICATION TO BE ADMINISTERED AT SCHOOL

Name:______________________________________ Grade:____________ Date: ____________

Medication:____

Dose:____________________ Time:__________________________ Route:________________

Diagnosis/Reason for medication:____

Licensed Healthcare Provider Signature:_______________________________________
(MD, DO, DDS, ARNP, or PA)

Printed Name of Licensed Healthcare Provider:__________________________________

PARENT/GUARDIAN PERMISSION TO ADMINISTER MEDICATION / INFORMATION EXCHANGE:

I hereby give my permission for ___________________________________ to take the above prescription at school as ordered.

I understand that it is my responsibility to furnish this medication. I understand that the medication is to be brought to school in the original container, appropriately labeled by the pharmacy or physician, stating the name of the medication, the dosage, and times it is to be administered. I understand the school policy regarding medication.

I further understand that any school employee who administers the medication to my child, in accordance with written instructions from the physician or dentist, shall not be liable for damages which might occur from an adverse medication reaction suffered by my child as a result of administering such medication.

I also give permission for the exchange of confidential health information between the school nurse, other representatives of my child's school, and the prescribing health care provider/pharmacy in the event a question or concern arises. I may revoke this consent to release information in writing and dated at any time except to the extent that action has been taken or information disclosed pursuant to signed consent. This consent shall remain in effect for a period of one year from signature date. To revoke this authorization, I should contact my child's school. Once information is disclosed, it may no longer be subject to HIPAA protections.

Date:____________________ ____

Signature of Parent/Guardian

MEDICATION ADMINISTRATION RECORD

School Year:______________________________

Student Name:____________________________ School:_________________________________ Teacher:________________________________

Medication:______________________________ Provider:_______________________________ Note Received:__________________________

Dose:_______________ Time:_______________ Route:________________ Comments:____

School Nurse:_____________________________ Initials:_____________

	1	2	3	4	5	6	7	8	9	10	11	12	13	14	15	16	17	18	19	20	21	22	23	24	25	26	27	28	29	30	31
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Name Initials Name Initials

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Name Initials Name Initials

A: Absent
NA: None Available
PN: Parent Notified
MD: Missed Dose

/: Weekend
/: No School
Ref: Refused
FT: Field Trip