



Kearney Public School
Health Services

Parental Request for In-School Medication

Name \_\_\_\_\_ Date of Birth \_\_\_\_\_

School \_\_\_\_\_ Grade \_\_\_\_\_ Teacher \_\_\_\_\_

I give permission for \_\_\_\_\_ to be given the following medication by the School Nurse or other unlicensed trained school personnel:

Form with fields: Name of Medication, Dosage of Medication, Date/s to be given, Time to be given/intervals in between doses, Route of Medication, Purpose of Medication

Prescription medication: The medication must be in the original container with a current pharmacy label that includes: student name, medication, dose and time, date of prescription and the physician's name. Medication can only be given as instructed on the label.

Over the Counter medication: The medication will be provided by the parent, be in the original container, and labeled with the student's name, dose and time. Medication can only be given as directed on the bottle for age and dose. Any changes in the manufacturer's recommendation will require a written order from the physician.

Any medication not properly labeled or stored can not be given at school. No medication can be given without completion of this form. Medication can be withheld based upon nursing assessment. Parents will be notified.

All medications must be stored at the school nurse office, unless all requirements for self-management of a condition have been met.

Self Management Requirements

- Written request/authorization of the student's parent/guardian
Receipt of a signed no-liability statement by parent/guardian
Written authorization of the student's physician
Development of a Self-Management Plan for the student
Documentation of successful demonstration of student's management skills by the School Nurse

I am not aware of any side effects, adverse reactions or any other problems my student is experiencing with this medication. I understand that I am primarily responsible for monitoring the effects of this medication. The School Nurse has my permission to contact Dr. \_\_\_\_\_ or his designee, regarding this medication.

Parent/Guardian signature \_\_\_\_\_

Date \_\_\_\_\_

Parent phone number in case of questions: \_\_\_\_\_