PCSD MEDICATION PERMISSION FORM

THIS FORM IS REQUIRED FOR ALL MEDICATIONS ADMINISTERED AT SCHOOL

Student Name:_____ DOB: _____School: _____Grade:___

- As per State law 53A-11-601, medication may only be administered to a student if: (a) the student's parent or legal guardian has provided a current written and signed request that the medication be administered during regular school hours to the student, and (b) the student's health care provider has prescribed the medication and provides documentation as the method, amount, and time schedule for administration, and a statement that administration of medication by school employees during periods when the student is under the control of the school is medically necessary.
- Any change in medication administration (i.e. dosage) requires a NEW medication form to be filled out by your Health Care Provider.
- Students in grades K-7 may NOT carry any medications (prescription and non-prescription) on their person.
- Students in grades 8-12 may NOT carry prescription medications on their person, but may carry a ONE DAY SUPPLY of non-prescription medication in the original container for their personal use only.
- All students may carry EpiPens, asthma inhalers, pancreatic enzymes, and diabetic supplies when indicated in the student's school health plan.
- Narcotic pain medication will not be administered by school personnel.
- MEDICATION MAY NOT BE SHARED
- Employees have been instructed to follow the Health Care Provider's instructions explicitly. Nurses and delegated staff members (unlicensed personnel) are not liable for any adverse reaction suffered by the student as a result of taking the medication (53A-11-601).

A healthcare Provider's signature is required for all non-prescription and prescription medications.

NON-PRESCRIPTION (OVER-THE-COUNTER) MEDICATION

Medication Name _____Reason_____

Dosage _____Route _____ Time _____

Side Effects _____

PRESCRIPTION MEDICATION

Medication Name _____Reason_____

Dosage _____Route _____ Time_____

Side Effects _____

It is medically necessary for this medication to be given during school hours.

Health Care Provider's Name_____

Phone _____ Fax _____

Heath Care Provider Signature _____Date _____

I acknowledge that I have read and understand the medication policy as it applies to my child.

Parent/Guardian Signature _____ Date _____

School Nurse Signature _____ Date _____

Staff Signature _____ Date _____