



City of St. Charles R-6 School District
400 North Sixth Street, St. Charles, MO 63301

NON-PRESCRIPTION Medication Form for Grades 5-12
(Excludes Lewis and Clark, Y.E.S. and R.E.S.)

Building: _____ Phone: _____
 Contact: _____ Fax: _____ School Year: _____

ADMINISTRATIVE PROCEDURES FOR GIVING NON-PRESCRIPTION MEDICINE AT SCHOOL

The giving of medicines by the nurse, principal, or designee shall be restricted to necessary medicines that cannot be given on an alternative schedule. All non-prescription medicines will be presented in the original container with the seal intact.

Procedure for the administration of non-prescription medicine:

1. The following form must be completed, signed, and dated by the parent/guardian.
2. Medication must be provided in the original container with the seal intact.
3. Only label directions will be followed. Any request in excess of label directions will require a prescriber order.
4. Non-prescription medicine will be permitted in the school or administered in the school *only* in accordance with this procedure.
5. Medicine name, dosage and instructions must be in English.
6. Medication containing aspirin will not be given without a doctor's order.
7. **Administration of acetaminophen/ibuprofen is limited to 12 doses per school year. More than 12 doses per school year will require an order by an authorized provider.**

Student's Name: _____ Date of Birth: _____ Grade: _____

Known Drug Allergies: _____

Medicine: _____

Dose and route: _____ Time/Interval to be given: _____

Diagnosis/Indication for use: _____

Start Date: _____ Discontinue Date: _____

I request that the St. Charles School District's designated personnel administer the above medicine to my child. I also understand that it is the right of the nurse to refuse to give any medicine that does not meet the criteria established by the St. Charles School District policy.

I give the District nurse my permission to contact my child's healthcare provider if there are any questions or concerns regarding the administration of this medication.

I will inform school personnel of any change in the student's health or change in medication.

 Parent/Guardian Signature Date () Home Phone () Work Phone

 Healthcare Provider (Please print) () Office Phone () Fax Number

MEDICATION FORM MUST BE RENEWED YEARLY