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

PRESCRIPTION MEDICATION FORM GRADES 5-12

Building: _____ Phone: _____

Contact: _____ Fax: _____ School Year: _____

ADMINISTRATIVE PROCEDURES FOR GIVING 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. Prescription medicines will be in the original pharmacy/prescriber labeled container showing: **a)** student's name **b)** name of medicine **c)** dosage and administration schedule **d)** prescriber's name and **e)** date purchased. The student's authorized prescriber is a medical professional with prescriptive authority such as a physician, dentist, orthodontist, etc. **The District will not administer the first dose of an initial prescription**.

Procedure for the administration of prescription medicine:

1. The following form must be completed, signed and dated by the prescriber and parent/guardian.
2. Medication will be provided in the original container appropriately labeled. Note: ask the pharmacist for an extra labeled container so you can have one for school and one for home.
3. Prescription pills brought to school by a student must have a signed and dated note from a parent/guardian stating the number of pills sent to school. The pills must be taken to the clinic by the beginning of classes that day.
4. 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.

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

TO BE COMPLETED BY PHYSICIAN:

Medicine, dose and route: _____

Time/interval to be given: _____ Start date:_____

Known Drug Allergies: _____ Discontinue date: _____

Possible Side Effects to be observed: _____

Diagnosis/Indication for use:_____

(Signature of parent/guardian or independent student below gives permission to release this information.)

I request that the St. Charles School District administer this medicine to this student.

_____	_____	_____
Printed Name of Physician	Signature of Physician	Date

_____	_____	_____
Address of Physician	Phone Number of Physician	Fax Number of Physician

TO BE COMPLETED BY PARENT/GUARDIAN:

I request that the St. Charles School District's designated personnel administer the above medicine to my child.
I also give permission for the authorized prescriber to release the required information for safe administration of this medicine at school. I understand that the nurse has the right to question any medication order he/she deems potentially inappropriate, and to verify the validity of any medication order. I also understand that it is the right of the nurse to refuse to give any medicine that he/she feels does not meet the criteria established by Nursing Procedure and the St. Charles School District.
I will inform school personnel of any change in the student's health or change in medication and understand that an additional written request for any change of this medicine must come from the authorized prescriber.

_____	_____	_____	_____
Parent/Guardian Signature	Date	Home Phone	Work Phone

MEDICATION FORM MUST BE RENEWED YEARLY