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

NON-PRESCRIPTION MEDICATION FORM GRADES 5-12

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 will 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 approximately 12 doses per school year. More than 12 doses per school year may 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