Permission for Prescribed Medication

HEALTH SERVICES DEPARTMENT
Waynesville R-VI School District
http://waynesville.k12.mo.us/

Date form received by the school _____/_____/_____

Student's Name _____ Date of Birth: _____

To Be Completed By Physician:

Name of medication: _____ Form: _____

Reason for medication: _____

Instructions (schedule and dose to be given at school): _____

_____

Start Date: _____ Stop Date: _____

☐ for episodic/emergency events only

Restrictions and/or important side effects: _____

_____

☐ I have attached a treatment plan for managing student's condition as addressed in student's 504 plan or Individual Education Plan.
☐ I have instructed student in the correct and responsible use of medication.
☐ Student has demonstrated to me or my designee the skill level necessary to self-administer medication according to treatment plan.
☐ This student is both capable and responsible for self-administering this medication according to treatment plan.
  ☐ Yes – supervised
  ☐ Yes – unsupervised

For School Nurse:
Date: _____
student demonstrated skill to nurse.

This student may carry this medication: ☐ Yes ☐ No

Physician's Signature: _____ Date: _____

Physician's Name (please print): _____

Address: _____ Phone: _____

To Be Completed by Parent/Guardian:

I hereby give permission for my child, _____, to receive the above medication at school according to school policy. I release the school district from any responsibility of my child's misuse or inappropriate use of medication.

Parent's Signature: _____ Date: _____

Medications should be brought in original containers only.

Rev. 06/12

MEDICATION RECORD

Student Name: _____ Date of Birth: _____ Sex: _____ Grade: _____

Medication: _____ Dosage: _____ Time: _____ School Year: _____

Pharmacy: _____ ID#: _____ Route: _____

Person administering medication must initial and state time IN the box:

	1	2	3	4	5	6	7	8	9	10	11	12	13	14	15	16	17	18	19	20	21	22	23	24	25	26	27	28	29	30	31
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Special Instructions:

Final Disposition: *Circled item indicates parent contacted/meds low* INIT NAME

Codes					
-	Weekend	F	Field Trip	Prescription Depleted	
H	Holiday	D	Early Dismissal	Medication Discontinued	
A	Absent	W	Dose Withheld	Medication Returned to Parents	
N	None Available	O	No show	Medication Destroyed	
				Date ___/___/___ By	