Parents, **Revised 2016**

We will gladly assist your child with all medication needs, but the following state regulations must be adhered to. Remember all **medical forms** are only valid for current school year and need to be completed **yearly.**

MEDICATION AT SCHOOL

1. **All medication**, whether prescription or over-the-counter, **MUST** have a signed "School Medication Prescriber/Parent Authorization" form for **EACH** medication.
2. **For prescription medications**, a physician signature AND a parent signature is required. NO PRESCRIPTION MEDICINES WILL BE GIVEN WITHOUT BOTH SIGNATURES ON THIS FORM.
3. **For over-the-counter medications** (including cough drops, ointments/creams, sunscreen, Neosporin, vitamins, Visine, Motrin, Tylenol, Advil, Pepto Bismol, etc.) a "School Medication Prescriber/Parent Authorization" form is also needed. The parent's signature will allow medication to be given for **two weeks**. If medication is needed for a longer period of time, a physician's signature will be required. The parent must also provide the medication that the child needs to take. **Schools are not allowed to keep stock medicines such as Tylenol or Advil. No exceptions will be made.** No medication may be administered at school until **BOTH** signed permission and medication are obtained. While on field trips, parents are allowed to carry and administer medications to their student **ONLY.**
4. **All medication** must be brought in the original, **UNOPENED** container. Prescription medication must be brought in a current pharmacy labeled container with student's name, physician name, name of medication, strength, dosage, time interval, and route. **No medication will be accepted loose in a plastic bag or unidentifiable container.**
5. All medication is to be delivered **by the parent** to the nurse or an adult in the office. **Do not send medication to school with your student.** We do not want to place your child in the position of being responsible for medication until the appropriate school personnel can take possession of it. No student will be permitted to carry or possess any type of medication, whether Prescription or Over-the-Counter, on his/her person at any time **(except EMERGENCY MEDICATIONS and approved medications prescribed for self-administration).** **Students found possessing medication will be subject to disciplinary action under Section 3.07 of the Code of Student Conduct.**
6. **Controlled medications**, like Ritalin, **must** be counted when brought to school. Please wait while the nurse or school employee counts the medication. The parent and school employee will be required to sign the back of the Medication Administration form verifying the medication count.
7. School personnel will not administer natural remedies, herbs and/or nutritional supplements without the explicit order of an authorized prescriber, parent authorization, verification that the product is safe to administer to children in the prescribed dosage and reasonable information regarding therapeutic and untoward effects.
8. If your child has any **food allergies**, you will need to have a "Diet Prescription for Meals at School" form completed and signed by **both** the physician and parent to turn into the school nurse.

All forms will be available to you on our website under Healthcare Services. Please feel free to call with any questions.

ALABAMA STATE DEPARTMENT OF EDUCATION

SCHOOL MEDICATION PRESCRIBER/PARENT AUTHORIZATION

School Year: _______ - _______

STUDENT INFORMATION

Student's Name: ______________________________ School: ______________________________

Date of Birth: ____/____/____ Age: ________ Grade: _____ Teacher: __________________

☐ No known drug allergies---if drug allergies list: ______________________ Weight: _______pounds

PRESCRIBER AUTHORIZATION (To be completed by licensed healthcare provider)

Medication Name: ____________________________ Dosage: ____________Route: ____________

Frequency/Time(s) to be given: ________________ Start Date: ___/___/___ Stop Date: ___/___/___

Reason for taking medication: ______________________________

Potential side effects/contraindications/adverse reactions: ______________________________

Treatment order in the event of an adverse reaction: ______________________________

SPECIAL INSTRUCTIONS:

Is the medication a controlled substance? Yes ☐ No ☐

Is self- medication permitted and recommended? Yes ☐ No ☐

If "yes" I hereby affirm this student has been instructed On proper self-administration of the prescribe medication.

Do you recommend this medication be kept "on person" by student? Yes ☐ No ☐

Printed Name of Licensed Healthcare Provider: ________________Phone: ( ) ______-______ Fax: _____-______

Signature of Licensed Healthcare Provider: ____________________________________ Date: ______________

PARENT AUTHORIZATION

I authorize the School Nurse, the registered nurse (RN) or licensed practical nurse (LPN) to administer or to delegate to unlicensed school personnel the task of assisting my child in taking the above medication in accordance with the administrative code practice rules. I understand that additional parent/prescriber signed statements will be necessary if the dosage of medication is changed. I also authorize the School Nurse to talk with the prescriber or pharmacist should a question come up with the medication.

Prescription Medication must be registered with School Nurse or trained Medication Assistants. Prescription medication must be properly labeled with student's name, prescriber's name, name of medication, dosage, time intervals, route of administration and the date of drug's expiration when appropriate.

Over the Counter Medication must be registered with the School Nurse or Trained Medication Assistant, OTC's in the original, unopened and sealed container. Local Education Agency Policy for OTC medication to be followed:

Parent's/Guardian's Signature: ________________________Date: ___/___/___ Phone: ( ) ______-______

SELF-ADMINISTRATION AUTHORIZATION

(To be completed ONLY if student is authorized to complete self-care by licensed healthcare provider.)

I authorize and recommend self-medication by my child for the above medication. I also affirm that he/she has been instructed in the proper self-administration of the prescribed medication by his/her attending physician. I shall indemnify and hold harmless the school, the agents of the school, and the local board of education against any claims that may arise relating to my child's self-administration of prescribed medication(s).

Signature of Parent: ________________________________ Date: ___/___/_____ Phone: ( ) ______-______

revised 5/2014