Colfax-Mingo Community School District-Medication Administration Form *(Developed May 2, 2019)*

ADMINISTRATION OF MEDICATION TO STUDENTS:

1. To maintain the safety of all students a responsible adult will transport medication to and from school.
2. Medication will be supplied in the original prescription bottle or manufacturer packaging and will be correctly labeled.
3. Expired or improperly labeled medication will not be given.
4. The first dose of medication should be given at home. (With the exception of emergency relief medications).
5. A parent or legal guardian must provide written authorization for medication administration.
6. This consent is only good for the current school year.

This form must be completed and returned to the health office before medication will be administered at school.

Student Name:____ Date of Birth:____________________

Medication:____

Dosage:________________________________ Time Given at School:________________________________

Diagnoses/Reason for Medication *(Optional)*:____

Prescriber's Name:____ Phone Number:______________________

Late Start Days: I will give the medication at home: __________ Please give the medication at school:________

Early Dismissal Days: Please give medication at school: _______Child will take medication at home: _________

Special Instructions:

It is necessary for my child to be given medication during school hours. I give my permission for the school nurse, or designee to administer the medication listed above. I agree that the student has experienced no previous side effects from the medication. I further understand that it may be in my child's best interest for the health staff to share this medication information with other school staff (teacher, counselor, etc. as necessary) and give permission to do so if needed. The school nurse has my permission to contact the prescribing physician if necessary.

Parent/Guardian Name:____ Date:____________________

***SIGNATURE:____ Phone Number:_____________**

<u>IF THERE IS UNUSED MEDICATION AT THE END OF THE SCHOOL YEAR:</u> (Please check one)

_____I will pick up any remaining medication at the end of the school year.

_____Please dispose of any remaining medication on the last day of school.

***Parent/Guardian Signature:____ Date:____________________**

SELF-ADMINISTERED AND POSSESSION OF MEDICATIONS

(3rd - 12th GRADE SEVERE ALLERGY/ASTHMATIC/DIABETIC STUDENTS ONLY)

<u>Epipen, inhaler, and/or Insulin injections ONLY</u>

I request authorization for my child to self-administer the above medication. I verify he/she is capable and responsible for self-administering the medication:

_____With Assistance _____Without Assistance

***Parent/Guardian Signature:____ Date:____________________**

Epipen, inhaler and/or insulin injections ONLY I request authorization for my child to have possession of the above medication. I verify he/she is capable and responsible for having possession of this medication:

***Parent/Guardian Signature:____ Date:____________________**