Cedar Rapids Community School District

CEDAR RAPIDS COMMUNITY SCHOOL DISTRICT
MEDICATION ADMINISTRATION PERMISSION FORM
Administration of Medication to Students

Only medication prescribed by a legal prescriber* will be administered during the time the student is at school. A legal prescriber's signature is required for administration of any non-prescription medication. All medications administered at school must be FDA approved. The parent or legal guardian will provide written authorization. The school will have the right to contact the prescriber's office to confirm or clarify medication instructions. All medication, prescription and over the counter, will be supplied to the school in the original container, properly labeled, and will be administered only by the school nurse or other personnel who have successfully completed a state approved medication administration course. By law, students with asthma or other airway constricting diseases may self-administer their medication with approval of their parents and prescribing health care providers. All medication will be stored in a secure area. Medication records will be kept confidential *__Legal Prescriber – physician, dentist, podiatrist, licensed physician assistant, advanced registered nurse practitioner.__

**__Middle and High School students__, in accordance with Health Services protocols for common complaints of pain, may have limited, over-the-counter medication with written parental consent.

- Non-prescription medication includes all over the counter products, like cough syrup, cough drops, enzymes, vitamins.
- The medication must be kept in the Health Office unless the school nurse authorizes otherwise.
- Prescription container labels must include the following information: name of medication, strength and quantity, dosage, prescription serial number, name and address of pharmacy, date prescription is dispensed, time to be given, name of doctor, name of student, and route of administration.
- The time of medication administration may need to be altered slightly to fit your child's schedule. Please remind your child that she/he is responsible to go to the Health Office at the appropriate time.

This form must be completed and returned to the school Health Office for your child to have prescribed medication administered at school.

Name of Student: _____ Date of Birth: _____

School: _____ Grade: _____ Teacher: _____

Name of Medication: _____ Dosage: _____

Prescriber's Name: _____ Prescriber's Signature: _____
(Required only for over the counter medications)

Approximate time to be given at school: _____ Route if other than oral: _____

Give medication on early dismissal days? Yes _____ No _____ Time _____

Give medication on two hour delay days? Yes _____ No _____ Time _____

Length of time medication to be given (if known): _____

Health condition for which medication must be given at school: _____

I request the above student be given this medication at school. The student has experienced no previous side effects from the medication. I further agree that school personnel may contact the prescriber as needed and that medication information may be shared with school personnel who need to know to provide appropriate services to this student.

_____	_____	_____
Parent/Legal Guardian	**Date**	**School Nurse**

RELEASE OF INFORMATION

I give my permission for exchange of information between school and _____
(Health Care Provider/Facility)
to be of assistance in the medical management of above student for the duration of this school year.

My signature authorizes release of information relating to ☐mental health ☐ substance abuse ☐ HIV/AIDS

_____	_____
Parent/Legal Guardian Signature	**Date**