# MEDICATION ADMINISTRATION IN SCHOOLS

The following rules for the administration of medication in schools applies to BOTH prescription and non-prescription (e.g., Tylenol, cough syrup) medications in the school setting. No medication will be administered unless the following requirements are me:

1. A written order from the physician to include the name of the pupil, name of the medication, dosage, the time the medication is to be administered at school and length of time to be given.
2. A written medication administration form completed by the parent/guardian releasing the school and the school personnel from any liability thereof. Medications are administered by a school nurse or designated responsible person. Medication Administration forms are available at the school office and from the school nurse.
3. Medications are to be delivered to the school by the parent/guardian or a designated responsible person.
4. All medication must be in the original container and clearly labeled.
5. Controlled medications (e.g. Ritalin) require a thirty-day physician's renewal.
6. At the end of the school year, medications must be picked up at school by the parent/guardian. Any remaining medication will be destroyed.
7. If self-administration of a medication is prescribed, the parent/guardian and the authorizing physician must complete the medication administration form.

School personnel shall not provide pupils with any medication until all the requirements are met.

# MEDICATION ADMINISTRATION FORM

I request that the enclosed medication in the original container be administered to my child as prescribed, and shall release school personnel from all liability. **This includes ALL over the counter medication** e.g.Tylenol, Ibuprophen, Benadryl, cough syrup, etc.

Name of Child _____ Grade _____

Name of Medication _____

Dosage _____

Purpose _____

_____

_____ _____

**Parent/Guardian Signature** Date

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## TO BE FILLED IN BY SCHOOL NURSE

Prescription # _____ Date_____

Pharmacy _____ Phone _____

Name of Medication_____

Name of Physician _____ Phone _____

# Of Tablets Received _____

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## PHYSICIAN'S ORDERS

Name of Patient_____

Name of Medication_____

Date of Prescription_____

Dosage_____

Purpose_____

COMMENTS_____

_____

Doctor's Name (please print) Doctor's Signature Date