

**PHYSICIAN'S RECOMMENDATION FOR SELF-ADMINISTRATION OF  
PRESCRIBED MEDICATION**

Dear Doctor:

The parents of the student named below have advised us of your desire to have their son/daughter carry a prescription medication on their person for self-administration during school hours.

Our School Board Policy relating to student medication use on campus requires all medication to be stored in the health office. Pupils are not allowed to have medication in their possession at school, walking to or from school or on the school bus. This practice provides for the safety of all students on campus (should the medication be lost) and protects the affected student in the event the medication is not used properly, or it does not provide relief, necessitating further care.

If, in your opinion, this student's medical condition requires immediate treatment with a prescribed medication and this student's well-being is in jeopardy unless it is carried on his/her person, the statement below needs to be signed by you and the parents for submission to our administration.

Thank you.

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**This request is to be filled in and signed by a licensed physician; the request should then be signed by the parent/guardian and returned to school.**

Pupil Name: \_\_\_\_\_ Date of Birth: \_\_\_\_\_ Grade: \_\_\_\_\_

The above named student is under my care. His/her condition warrants immediate use of the medication listed below, and it is required that this medication be carried on his/her person. This student has demonstrated knowledge of correct dosage, usage and precautions. Medication is to be used by above student as follows:

Medication: \_\_\_\_\_ Form of medication: \_\_\_\_\_

Dosage: \_\_\_\_\_ Time/Frequency: \_\_\_\_\_

Medication Start Date: \_\_\_\_\_ Stop Date: \_\_\_\_\_

Physician Signature: \_\_\_\_\_ Date: \_\_\_\_\_

Physician Name: (please print) \_\_\_\_\_ Phone: \_\_\_\_\_

Physician Address: \_\_\_\_\_

ALL PARTIES SIGNING THIS FORM, AND IN SO SIGNING, AGREE TO HOLD THE SCHOOL AND/OR ITS PERSONNEL FREE FROM ANY OR ALL SUITS WHICH MIGHT ARISE OUT OF THESE ARRANGEMENTS.

Parent Signature: \_\_\_\_\_ Date: \_\_\_\_\_

Student Signature: \_\_\_\_\_ Date: \_\_\_\_\_

***This form must be renewed whenever the prescription changes and is valid through June of this academic year. A new form is required each year.***

## **REGULATIONS ON THE SELF-ADMINISTRATION OF MEDICATION DURING SCHOOL HOURS**

No pupil shall be given medication, **prescription or over-the-counter**, during school hours except upon written request from the parent or guardian of the pupil and a licensed physician who has the responsibility for the medical management of the pupil.

A request form for each prescribed medication **MUST** be completed by the pupil's physician, signed by the parent or guardian, and filed with the school. **The prescription label on the medication container is not acceptable as a physician's statement. Over-the-counter medications will be given only if prescribed by a physician or dentist.**

Medication must be provided to the school in the container in which it is purchased, with the prescription label attached, and must be prescribed for the student to whom it will be administered. The container must be clearly labeled with the following information:

- a) Pupil's full name
- b) Physician's name
- c) Name of medication
- d) Dosage, schedule and dose form
- e) Date of expiration of prescription

Each medication is to be in a separate container labeled as above. **Medication cannot be brought to school in a plastic bag, plastic ware, or any other repackaging.**

The pupil will assume responsibility for keeping the medication in a secure location where it is not accessible to other students.

The pupil will take medications according to the physician's instructions.

The pupil will demonstrate proper use of medication to the District Nurse.