Roland- Story Community School District
Medication Administration Permission Form

Administration of Medication to Students

1. Only medication prescribed by a legal provider will be administered at school.
2. A parent or legal guardian must provide written authorization.
3. Medication will be supplied in the original container with proper labeling. Expired or improperly labeled medication will not be given.
4. This consent is only valid 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: _____ **DOB:** _____

Grade/Teacher: _____

Medication: _____

Medication Directions: _____

Reason for Medication: _____

Physician/Prescriber name: _____ **Phone:** _____

On late start days: *I will give medication at home* ____ *Please give medication at school* ____
With early dismissal: *I would like medication given at school* ____ *Child will take at home* ____

Other Special Instructions: _____

_____

It is necessary for my child to be given medication during school hours. I give my permission for the school nurse, or trained 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 printed name: _____

Signature: _____ **Date:** _____

**Please initial option:*

_____ I will pick up any unused medication at the end of the school year
_____ Please discard any unused medication.