

MARION INDEPENDENT SCHOOL DISTRICT

Student Personnel

Series 500

Policy Title ADMINISTRATION OF MEDICATION TO STUDENTS

Medication Administration Authorization

To ensure compliance with the Board Policy for Medication Administration, the following **MUST** be completed:

- Parents have completed and signed the Medication Administration Authorization form for all prescribed or over-the-counter medication.
- The medication is in the original, labeled container as dispensed by the pharmacy or as bought in the manufacturer's labeled container.
- The medication label contains the student's name, name of medication, dosage, directions for use, and date.
- Authorization is renewed annually and immediately when the parent notifies the school that changes are necessary.

Student name _____ Birth date _____

School _____ Teacher/Grade _____

Name of Medication _____ Dosage _____

Route (by mouth, etc.) _____ Time to be given _____

Reason for Medication _____

Possible Side effects/special instructions _____

Physician Name _____ Physician Phone _____

Start Date _____ Stop/reevaluate Date _____

I request the above student receive the above medication at school and at school activities, according to the prescription and instructions. I understand the school will keep a written record. This information is confidential except as stated in the Family Education Rights and Privacy Act (FERPA). I agree to coordinate and work with the school personnel and the physician when questions arise. I agree to provide safe delivery of the medication and the equipment to and from school and to pick up the remaining medication/equipment.

Parent Signature _____ Date _____

Parent's address _____ Phone _____