School Year:_____ Student Name:_____

Warren County R-III School District
MEDICATION POLICY

Prescription medication will be given by school personnel. Medication must have a pharmaceutical label stating (1) child's name, (2) name of medication and instruction as to dosage, time, etc. (3) name of doctor prescribing medication and, (4) a current date. Medications will only be administered as stated on the prescription label.

Parents may not send medicine with their child to school. It is the responsibility of the parent or legal guardian to bring the medicine to school.

It should not be necessary to give more than one dose of medication per day during a six-hour school day. Most medication schedules can be arranged so that all doses of medication are taken at home. Exceptions can be arranged with the school nurse.

Students who require emergency medication should have their medication properly labeled as described above. Specific written instruction needs to be provided as to when and under what circumstances medication is to be given. This information will be provided and signed by the student's physician annually.

The district may administer over-the-counter medication to a student upon receipt of a written request and permission to do so by a parent/guardian. The district will provide Advil or generic substitute, Tylenol or generic substitute, upon written permission from parent/guardian up to six (6) doses per semester for students in Kindergarten through 5th grade and up to twelve (12) doses per semester for students in 6th through 12th grades. Further dosage will only occur with written doctor's permission. Please note that the summer school dosage is only up to four (4) doses during the complete summer school period for all students.

Please check the following over-the-counter medication(s) the district is authorized to distribute to your student:

- ☐ **Acetaminophen (generic Tylenol—provided by district) (Dosage by weight)**
- ☐ **Ibuprofen (generic Advil—provided by district) (Dosage by weight)**
- ☐ **Antacid (generic Tums —provided by district) (Dosage by weight)**
- ☐ **Cough Drops (generic—provided by district) (Dosage by weight)**
- ☐ **DO NOT GIVE**

Student Name:_____ **Grade:**_____

_____ _____
Signature of Parent/Guardian Date

MEDICATION AUTHORIZATION FORM

I request that the nurse or designated school staff member give:
Name of prescribed medication _____ Exact dosage_____ at _____(time)
Medication to be given from _____ to _____ or as needed _____
Condition for which medication is prescribed: _____
Precautions, possible adverse reaction and interventions: _____

Name of prescribed medication _____ Exact dosage_____ at _____(time)
Medication to be given from _____ to _____ or as needed _____
Condition for which medication is prescribed: _____
Precautions, possible adverse reaction and interventions: _____

Name of prescribed medication _____ Exact dosage_____ at _____(time)
Medication to be given from _____ to _____ or as needed _____
Condition for which medication is prescribed: _____
Precautions, possible adverse reaction and interventions: _____

I give my permission for reciprocal exchange of information from Dr. _____ to the Warren County R-III Schools regarding my child. All information received is strictly confidential.
****ALL AUTHORIZATIONS EXPIRE AT THE END OF THE SCHOOL YEAR (INCLUDES SUMMER SCHOOL)****

_____ _____
Parent/Guardian Signature Date

_____ _____
Physician's Signature Phone Number

Please complete this form and return with properly labeled medication(s) to the School Nurse's Office.

Revised 05/11/Reviewed 03/12, 01/13, 05/16

SCHOOL YEAR: _______ STUDENT NAME: ____ GRADE: _______

WARREN COUNTY R-III SCHOOL DISTRICT
MEDICATION POLICY

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Students who require emergency medication should have their medication properly labeled as described above. Specific written instruction needs to be provided as to when and under what circumstances medication is to be given. This information will be provided and signed by the student's physician annually.

MEDICATION AUTHORIZATION FORM

I request that the nurse or designated school staff member give:

Name of prescribed medication __________________________ Exact dosage__________________ at ______________ (time)
Medication to be given from ___________ to ___________ or as needed ___________________
Condition for which medication is prescribed: ____
Precautions, possible adverse reaction and interventions: __________________________________

Name of prescribed medication __________________________ Exact dosage__________________ at ______________ (time)
Medication to be given from ___________ to ___________ or as needed ___________________
Condition for which medication is prescribed: ____
Precautions, possible adverse reaction and interventions: __________________________________

Name of prescribed medication __________________________ Exact dosage__________________ at ______________ (time)
Medication to be given from ___________ to ___________ or as needed ___________________
Condition for which medication is prescribed: ____
Precautions, possible adverse reaction and interventions: __________________________________

Name of prescribed medication __________________________ Exact dosage__________________ at ______________ (time)
Medication to be given from ___________ to ___________ or as needed ___________________
Condition for which medication is prescribed: ____
Precautions, possible adverse reaction and interventions: __________________________________

Name of prescribed medication __________________________ Exact dosage__________________ at ______________ (time)
Medication to be given from ___________ to ___________ or as needed ___________________
Condition for which medication is prescribed: ____
Precautions, possible adverse reaction and interventions: __________________________________

I give my permission for reciprocal exchange of information from Dr. ____________________ to the Warren County R-III Schools regarding my child. All information received is strictly confidential.

****ALL AUTHORIZATIONS EXPIRE AT THE END OF THE SCHOOL YEAR - INCLUDES SUMMER SCHOOL****

____ _________________________
Parent/Guardian Signature Date

____ _________________________
Physician's Signature Phone Number

PLEASE COMPLETE THIS FORM AND RETURN WITH PROPERLY LABELED MEDICATION(S) TO THE SCHOOL NURSE'S OFFICE.