

Jonesville Community Schools

AUTHORIZATION FOR ROUTINE/SHORT TERM MEDICATION ADMINISTRATION

From Student-Parent Handbook-

*“Teachers cannot keep any medication in their rooms. Students are to bring all medicine to the school nurse in the **current prescription bottle with the doctor’s instructions** before the school can administer it. The school cannot dispense aspirin, cold remedies, or other nonprescription medication unless you send it from home with a note, which indicates precisely how you wish to have it dispensed. **All medications are to be sent in the original container.**”*

This policy will be strictly enforced. Most pharmacies will provide a bottle for home and for school if necessary. It is preferred that parents bring medication in to the school rather than send it to school with the student.

THE FOLLOWING INFORMATION IS NECESSARY FOR ANY STUDENT TO USE MEDICATIONS IN SCHOOL. PLEASE FILL IN ALL AREAS.

Name of Student

Date of Birth

Teacher’s Name

Please administer to the above named student the following medication:

Medication(What?)

Dosage (How much?)

Route (How is it given?)

Time of day to be given at **school**

Reason for Medication(Why is it being given?)

Date to be started **at school**

Stop Date

Prescribing Physician’s Name

Prescribing Physician’s Phone

Restrictions and/or adverse reactions: None Anticipated Yes Please explain:_____

Special Storage Requirements: None Refrigerate Other_____

I hereby request Jonesville Community Schools to supervise the medication routine and administration prescribed for my child. I have read the school’s policy and regulations pertaining to administration of medication.

1. I agree to follow the school’s policy and regulations regarding medication administration.
2. I will assume responsibility for use of medication in school, either by me or by my child.
3. I will notify the school immediately if there is any change in the use of the medication or the prescribed treatment.
4. I release and agree to hold the Board of Education, its officials, and its employees harmless from any and all liability for damages or injury resulting directly or in-directly from this authorization.
5. I give permission for the school to contact the above named physician and exchange information regarding this medication.

Please send a note Please call _____(phone number) when getting low or out of medication.

Signature of Parent/Guardian_____ Date_____

Physician’s Orders (please have physician complete and fax to school 517/849-7306):_____

Physician’s Signature_____ Date_____