

ATTENTION PARENT/GUARDIAN

In order to make administration of medications safe for staff and students, we ask that you adhere to the following guidelines:

1. Administration of medication is foremost the responsibility of the parent or guardian. All medications that can be given outside the school hours without serious effects must be given before and after school. Example, medication (i.e. antibiotics) that is to be given three times a day can be given at breakfast, after school, and at bed time unless otherwise indicated by a licensed prescriber.
2. If a dose of medication must be given during school hours, it can be administered at school as long as the following is in order:
 - a. Signed medication form by parent.
 - b. Signed medication form or prescription note by the licensed prescriber.
 - c. **ALL MEDICATION** must be in the original container/bottle and labeled with the child's name (no medication in baggies, boxes, etc.).
 - d. The first dose of a new medication must have been given by the parent/guardian at home in case of allergic reaction by child.
3. If any of the above medication guidelines in paragraph 2 regarding administration of medication during school hours has not been met, no medication will be administered to the student by school staff. These guidelines are directed by Monongalia County Schools Medication Policy and administration of any medication will become the responsibility of the parent until all the guidelines have been complied with.
4. Only send in enough medication to complete the required dosing administered at school (30 day supply is the limit). ***AT NO TIME WILL MEDICATIONS WILL BE SENT HOME WITH THE STUDENT. IT WILL BE THE RESPONSIBILITY OF THE PARENT/GUARDIAN TO PICK UP ALL REMAINING PRESCRIPTION MEDICATION(S) AND/OR NON-PRESCRIPTION MEDICATION(S) FROM THE SCHOOL.***

I have read the above statements and will follow the procedures and guidelines regarding medication administration at school as set forth by the Monongalia County Schools Medication Policy.

Signature of Parent/Guardian
Parent Medication Letter

Date

School _____

Monongalia County Schools Medication Form

Student Information

Student Name _____
 Birth Date _____ Last _____ First _____ Middle _____
 Age _____ Homeroom Teacher _____ Grade _____
 Medication Allergies _____
 Parent/Guardian Name (Print) _____
 Parent/Guardian Phone (Home) _____ (Work) _____ (Cell) _____

This section of the Medication Form is to be filled out by a licensed prescriber. Medication orders are valid for the current school year including any summer school programs or extended school year programs. A medication order is required for any prescription and non-prescription (over the counter) medication. If there is any change in medication, dosage, time, or route, a new medication order must be received before the medication can be administered by school personnel. By signing this form, the licensed prescriber is authorizing that this medication may be given at school.

Physician

Prescribed and Non-Prescribed Medication (Use one form for each medication)

Medication _____ Diagnosis/ICD-9 Code _____
 Dose _____ Time _____ Route _____
 Intended Effect of Medication _____
 Potentially Serious Side Effects for this Medication _____
 If rectal Diastat/Diazepam or Klonopin are prescribed, may this be administered by unlicensed, trained personnel?
 _____ Yes _____ No
 May the student self-administer their emergency medication per county policy? _____ Yes _____ No
 May the student carry their emergency medications on him/her per county policy? _____ Yes _____ No
 Name and Title of Licensed Prescriber (PRINT) _____
 Address _____
 Phone _____ Fax _____
 Signature of License Prescriber _____ Date _____

Parent/Guardian

Parent/Guardian Authorization

The first dose of this prescribed medication has been given at home? Yes No Parent Initial _____

I understand that the medication must be in the original container and properly labeled bearing the child's name.

I understand the licensed prescriber may be contacted concerning the medication order for reasons including, but not limited to, clarification, effectiveness, administration time, dosage, discontinuation, or new medication order.

I understand that, with due notification of licensed prescriber and parent/guardian, the school nurse/Monongalia County Schools may discontinue medication administration if student's health appears to be at risk.

I understand that medication administration and procedures may be delegated to school personnel who have been trained by and remain under direct or indirect supervision of the school nurse.

I understand a photograph of my child may be taken to assist in the correct administration of my child's medication.

I hereby give permission for my child to receive medication at school per the Monongalia County Schools Medication Policy and as ordered by my child's licensed prescriber.

Parent/Guardian Signature _____ Date _____