

## **MEDICATION ADMINISTRATION IN THE SCHOOL SETTING**

Certain medical diagnoses and illnesses require medication at school. The Mercer County Board of Education Administration of Medication Policy requires all prescription medication to be given per a physician's order and with written parent/guardian permission. Over-the-counter (OTC) medication (Tylenol, Motrin, etc.) requires written parent/guardian consent.

Other guidelines to keep in mind for all prescription and OTC medication:

- The initial dose of any medication should be administered at home unless otherwise directed by the licensed prescriber.
- All medication **MUST** be in the original container with the student's name, medication and dosage clearly identified.
- Parents should bring medication to the school to ensure that it arrives safely. Sending medication to school with the student is highly discouraged.
- Parents should retrieve any unused medication from the school.

For your convenience, the medication administration forms of both prescription and OTC medication is included on the next two pages.

**MERCER COUNTY SCHOOL HEALTH SERVICES**

**OVER-THE-COUNTER MEDICATION CONSENT FORM**

**I understand and agree to the following:**

All sections of this form **MUST** be completed before medication can be administered.

All medications should be given at home when possible. Medication sent to school in baggies, envelopes or other containers will not be administered and will not be administered to the student.

All medications **MUST** be in the original container.

All medications **MUST** state it is approved for use in children. If a medication is not approved for use in children, it may be administered with a physician=s order. You may obtain the proper form for physician ordered medications from the school.

**ALL MEDICATIONS MUST BE LEFT IN THE SCHOOL OFFICE**

**Student Name:** \_\_\_\_\_

**Birthdate:** \_\_\_\_\_ **Allergies:** \_\_\_\_\_

**Name of Medication:** \_\_\_\_\_

**Time To Be Given at School:** \_\_\_\_\_

**Amount To Be Given:** \_\_\_\_\_

**Reason for Medication:** \_\_\_\_\_

**I give my permission for school personnel to administer the above medication to the above-named student.**

\_\_\_\_\_  
(Signature of Parent/Guardian)

\_\_\_\_\_  
Date

\_\_\_\_\_  
Telephone No.

\_\_\_\_\_  
Cell No.

# MERCER COUNTY SCHOOL HEALTH SERVICES PRESCRIPTION MEDICATION ADMINISTRATION

ALL Sections of this form **MUST** be completed before medication is administered to a student.

STUDENT NAME \_\_\_\_\_ SCHOOL \_\_\_\_\_

BIRTHDATE \_\_\_\_\_ MEDICINE IS NEEDED\*: ALL YEAR  \_\_\_\_\_ WEEKS  OTHER: \_\_\_\_\_

ALLERGIES \_\_\_\_\_

The initial dose of any medication should be administered at home, except for emergency medication, unless otherwise directed by a licensed prescriber. Medication prescribed three times a day (Example: antibiotics) should be given before school, immediately after school and at bedtime. Therefore, administration of such medication at school is not warranted.

**TO BE COMPLETED BY PARENT:**

I, \_\_\_\_\_, GIVE PERMISSION FOR MY CHILD TO RECEIVE THIS MEDICATION AS DIRECTED.

TELEPHONE: HOME \_\_\_\_\_ WORK \_\_\_\_\_ OTHER NUMBERS \_\_\_\_\_

I WANT SCHOOL TO:  RETURN ANY EXTRA MED  
 RETURN CONTAINER  
 DISCARD MED/CONTAINER

\_\_\_\_\_  
PARENT/GUARDIAN SIGNATURE DATE

**TO BE COMPLETED BY DOCTOR:**

CHILD=S MEDICAL DIAGNOSIS: \_\_\_\_\_

NAME OF MEDICATION \_\_\_\_\_ DOSAGE \_\_\_\_\_ TIME OF IN-SCHOOL ADMINISTRATION \_\_\_\_\_

ROUTE: MOUTH \_\_\_\_\_ INHALE \_\_\_\_\_ RECTAL \_\_\_\_\_ INJECTION: IM \_\_\_\_\_ SQ \_\_\_\_\_

IF NORMAL MEDICATION TIME IS MISSED, SCHOOL STAFF  SHOULD  SHOULD NOT ADMINISTER AT A LATER TIME.

SPECIAL INSTRUCTIONS REGARDING MEDICATION (SIDE-EFFECTS, REACTIONS, COMMENTS, ETC.): \_\_\_\_\_

\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_  
DATE PRINTED DOCTOR=S NAME TELEPHONE DOCTOR=S SIGNATURE