

Student ID#: _____

Expiration Date: _____

School Year: 2015-2016

Med Location: _____



NORTH
KANSAS CITY
SCHOOLS
e s t . 1 9 1 3

Authorization for Medications to be Taken During School Hours

The following section is to be completed by the PARENT:

School _____			
Child's Name _____	_____	_____	_____
Last	First	Sex	Date of Birth
Physician's Name _____		Address _____	Telephone Number _____
<p>I give permission for the exchange of verbal and written communication between the physician and the school nurse regarding my child's medication regime.</p> <p>I request that my child be assisted in taking the medicine(s) described below at the school by authorized persons or permitted to medicate herself/himself as also authorized by me and my physician (see below). _____</p>			
_____	_____	_____	_____
Date	Parent/Guardian Signature	Date	Witness

The following section is to be completed by the PHYSICIAN:

Diagnosis for which medication is given: _____
Name of Medicine: _____
Form: _____ Dose: _____
State time for DAILY medication: _____
If medication is to be given WHEN NEEDED describe indications: _____
How soon can it be repeated? _____
Is child authorized to medicate herself/himself? _____
List significant side effects: _____
Length of time this treatment is recommended: _____

Other Information:

Date _____ Physician's signature _____



Educational Programs

Student Services

Medication Policy

When possible, we encourage medication be administered at home using a schedule that will not require doses during school hours. However, a child's health care provider may deem it necessary for medication to be taken during school hours. **If so, all prescribed medication must be accompanied by written permission from a licensed physician.**

MEDICATION GUIDELINES FOR ALL NORTH KANSAS CITY SCHOOLS ELEMENTARY, MIDDLE, & HIGH SCHOOLS

1. Written orders from a physician licensed to prescribe and written permission from the parent/guardian must be provided for any prescription to be given at school. The information will include name of the student, of the medication, dosage, route of administration, and time medication is to be taken.

(The physician may use his/her office letterhead or a school district "Authorization for Medication" form may be obtained from the school nurse, health room assistant, or administrative assistant.)

2. All prescription medication must have the label attached by the pharmacist/physician and will include on the container: the child's name, the name of the medication and the dosage, and the physician's name.
3. All non-prescription over-the-counter medication must be sent in the original container marked with the student's name and accompanied by a parent's authorization to administer. ONLY the instructions on the container will be followed unless the physician provides alternative instructions. If a question would arise, the school nurse will have the right to refuse administration of the medication until further clarification is received and documented from the physician.
4. Any change in the time or dosage of medication must be accompanied by a written request from the physician.
5. It is the student's responsibility to come to the health room for assistance in taking medication.
6. Medication should NOT be sent with students on the bus. PARENTS SHOULD DELIVER MEDICATION TO THE SCHOOL NURSE OR OFFICE CLERK. Medication should be picked up by the parent when the illness is concluded or at the end of the school year. The nurse will not send medication home with a student.