STUDENT MEDICATION FORM

2010-11

Dear Parents:

To comply with school policy, all medication is to be administered by school personnel and MUST be pre-approved in writing by the parent/guardian or doctor. A completed and signed SWCS "*Request for Administration of Medication Form*" needs to be on file at the school before any medication can be administered.

Students may not keep medication with them unless they have been designated as Self-Managers (certified and or authorized to self medicate) and cleared by the principal to do so. All medicine (including inhalers for asthma) must be secured in the classroom or school office before requesting that medicine be administered at school.

<u>THE MEDICATION MUST BE BROUGHT TO SCHOOL AS FOLLOWS:</u>

- ***<u>(DO NOT</u>*** **SEND MEDICATION IN BAGGIES OR TUPPERWARE)**.
- **OVER THE COUNTER MEDICATIONS MUST BE IN THE ORIGINAL PURCHASED CONTAINER/BOX.**
- **PRESCRIPTION MEDICATIONS MUST BE IN THE CONTAINER LABELED BY THE PHARMACIST.**
- **PRESCRIPTION LABELS SHOULD INCLUDE STUDENT NAME, NAME OF DRUG, THE DOSAGE AND TIMES, AND THE REASON FOR ITS USE.**

Please follow these steps:

1. **Doctor's signature** is necessary for the following treatment: epi-pens, bee sting kits, and inhalers.
2. **Parent/Guardian signature** is required for ALL over the counter medications (Tylenol, cough medicine, etc.) including naturopathic medications.

All medication **<u>MUST</u>** be given under adult supervision. This is for the safety of your child and others. If you have any questions, please contact the school office at 503-244-1697.

I HAVE READ AND UNDERSTAND THESE INSTRUCTIONS:____

Parent/ Guardian Sign Here

FILL OUT THE REQUEST FORM ON THE BACK OF THIS PAGE AND RETURN IT WITH STUDENT'S MEDICATION TO THE SWCS OFFICE.

Request for Administration of Medication by SWCS School Personnel

I hereby request and give my permission to the school staff to administer the medication listed above to my child. My signature releases the SWCS Board, its employees and representatives of all liabilities.

PLEASE PRINT

My child ____
(Name of Student)

should receive ____
(Name of Drug, Dosage)

at the following times ____
(List Detailed times)

Specific instructions for administration or storage of medication:

____

Possible reactions to watch for and report to parent:

____

Parent agrees to notify the person responsible for administering medication of the following:

1. Delivery of medication or new medications to the school.
2. Any change in medication or procedures.

Parent/Guardian Consent:

______________________ Signature

______________________ Printed Name

______________________ Date

Person(s) administering medication:

______________________ Signature

______________________ Printed Name

______________________ Date

24 Hour/Emergency Phone Number where parent/guardian can be reached: (_____)_______________ Home / Mobile / Work

Secondary Emergency Contact (_____)__________________ Contact Name ______________________

RETURN THIS FORM WITH STUDENT'S MEDICATION TO THE SWCS SCHOOL OFFICE