Red Rock Elementary School Medication Form

Parent Permission for Administering Medication to Students

Student Name:_____ DOB:_____ Grade:_____

Please read the following information before appointing a Health Assistant as your Agent

The district may allow you to appoint a Health Assistant or trained employee as your agent for the administration of your child's medication. In authorizing the health assistant to administer your child's medication, the district is not authorizing the assistant to perform duties of a professional licensed nurse. By appointing the health assistant as your agent, you are permitting the health assistant to act in your place. In the event that administration of the medication requires nursing judgment as determined by the district nurse, the district cannot allow you to appoint the health assistant as your agent and you will need to make other arrangements for your child's medication administration.

Please complete information and check appropriate boxes below

Medication_____Amount to be given:_____Time(s)_____

Give medication: _____Daily _____ As Needed

_____Prescription _____Over the Counter

Duration: From Date: _____ To Date: _____

Reason For Medication: _____

Drug or Food Allergy: _____

Statement of Understanding: All medications are to be provided by the parent or guardian and labeled in an original bottle. Prescription medications must have a pharmacy label with the student's name, medication name, amount and time to be given, and duration to be given. The health office must be notified by the ordering provider of any changes in dosage administration. The parent agrees to provide an extra prescription bottle with a current pharmacy label for field trips. If an extra bottle is not provided, health office staff will send the school bottle with its entire contents unless other arrangements are made. Over the counter medications will not be given for more than three consecutive days without an order from a physician. The amount to be given must be age or weight appropriate based on the manufacturer's recommended dosage.

Parent/guardian Permission to Administer Medication: I hereby authorize the health assistant or other trained designated district employee to be my agent to give the medication listed above to my child.

Signature: _____ Date:_____

Medication Administration Record School Year_____

Day	July	Aug	Sept	Oct	Nov	Dec	Jan	Feb	March	April	May	June
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Medication Counts		
Count	Date	Initials

Discontinued Medication/End of Year

Date:_____

Parent Signature:_____

Health Office Signature:_____