RENWICK USD 267 MEDICATION FORM

1. Fill in student's name, date of birth, grade and school.
   One form needs to be completed for each medication the student is taking.
2. Complete **Part A** for **<u>all medications</u>** for students in grades Pre-K – 12.
3. Complete **Part A and B** for students in grades 6-12 who need to carry and self-administer asthma or anaphylactic medications or students in grades 9-12 with over-the-counter medications.

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Student's Name ____ D.O.B. __________________

Grade/Teacher ____School __________________

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PART A – REQUEST FOR ADMINISTRATION OF MEDICATION

Medication& Dosage____

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Date medication started _________________________ Time to be given__________________

Diagnosis (es) ____

Physician Signature ____

(Physician signature *NOT REQUIRED* for over-the-counter meds *GRADES 9-12*)

Physician printed name____________________________________ Date __________________

Physician phone number ____

Parent or Guardian signature _______________________________ Date__________________

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PART B – REQUEST TO SELF-ADMINISTER MEDICATION
GRADES 6-12 – ASTHMA/ANAPHYLACTIC REACTION
GRADES 9-12 – OVER-THE-COUNTER MEDICATIONS

I request that my child be permitted to self-medicate at school. I request that my child be permitted to carry the medication with him/her. I understand my child will be responsible for knowing the location of the medications at all times. The school district and its officers, employees or agents incur no liability for damage, injury or death resulting directly or indirectly from this request to self-medicate. I have read the medication policy for Renwick USD 267 (Board Policy JGFGB and JGFGBA). A request for Administration of Medication at School **(Part A** of this form) has been completed.

The student has demonstrated the skill level necessary to use the medication as prescribed. I have discussed the following conditions with my child:

1. Immediately tell an adult when having breathing problems or a reaction.
2. Never share medication with anyone else.
3. Have prescription label on medication or write student name on over-the-counter medication.

Physician's signature (***prescription*** **meds only**) ____

Physician's printed name ____ Date __________________

Parent or Guardian signature____ Date __________________

NOTE: All medications are to be brought to school in the original container appropriately labeled by the pharmacy or physician, stating the name of the medication, dosage and time to be administered.