



WAYNESVILLE R-VI SCHOOLS

# Permission for Prescribed Medication

Date form received by the school \_\_\_\_/\_\_\_\_/\_\_\_\_

Student's Name \_\_\_\_\_

Date of Birth: \_\_\_\_\_

### To Be Completed By Physician:

Name of medication: \_\_\_\_\_ Form: \_\_\_\_\_

Reason for medication: \_\_\_\_\_

Instructions (schedule and dose to be given at school): \_\_\_\_\_

Start Date: \_\_\_\_\_

Stop Date: \_\_\_\_\_

for episodic/emergency events only

Restrictions and/or important side effects: \_\_\_\_\_

I have attached a treatment plan for managing student's condition as addressed in student's 504 plan or Individual Education Plan.

I have instructed student in the correct and responsible use of medication.

Student has demonstrated to me or my designee the skill level necessary to self-administer medication according to treatment plan.

This student is both capable and responsible for self-administering this medication according to treatment plan.

Yes – supervised

Yes – unsupervised

#### For School Nurse:

Date: \_\_\_\_\_

student demonstrated skill to nurse.

This student may carry this medication:  Yes  No

Physician's Signature: \_\_\_\_\_

Date: \_\_\_\_\_

Physician's Name (please print): \_\_\_\_\_

Address: \_\_\_\_\_

Phone: \_\_\_\_\_

### To Be Completed by Parent/Guardian:

I hereby give permission for my child, \_\_\_\_\_, to receive the above medication at school according to school policy. I release the school district from any responsibility of my child's misuse or inappropriate use of medication.

Parent's Signature: \_\_\_\_\_

Date: \_\_\_\_\_

**Medications should be brought in original containers only.**

## MEDICATION RECORD

Student Name: \_\_\_\_\_ Date of Birth: \_\_\_\_\_ Sex: \_\_\_\_\_ Grade: \_\_\_\_\_  
 Medication: \_\_\_\_\_ Dosage: \_\_\_\_\_ Time: \_\_\_\_\_ School Year: \_\_\_\_\_  
 Pharmacy: \_\_\_\_\_ ID#: \_\_\_\_\_ Route: \_\_\_\_\_

*Person administering medication must initial and state time IN the box:*

	1	2	3	4	5	6	7	8	9	10	11	12	13	14	15	16	17	18	19	20	21	22	23	24	25	26	27	28	29	30	31
Aug																															
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Special Instructions:

<b>Final Disposition:</b> <i>Circled item indicates parent contacted/meds low</i>		INIT	NAME
Codes	Prescription Depleted _____	_____	_____
- Weekend	F Field Trip	Medication Discontinued _____	_____
H Holiday	D Early Dismissal	Medication Returned to Parents _____	_____
A Absent	W Dose Withheld	Medication Destroyed _____	_____
N None Available	O No show	Date ___/___/___ By _____	_____