Pleasant Hill R-III School District

ADMINISTRATION OF MEDICATIONS TO STUDENTS

(Permission Form for Medications)

Medication will not be administered at school unless this form is completed. In order for district staff to be properly prepared for emergency situations, a Treatment/Emergency Action Plan appropriate for the Student's condition (ex. Asthma, Seizure, Diabetes, Anaphylaxis, etc.) should accompany this form, if necessary.

Student Information

Name: _____ Age: _____ Date of Birth: _____
Homeroom/Classroom _____ Grade: _____
Allergies: _____
Date Permission Form Received by the School: _____

Treatment/Emergency Action Plan

Treatment/Emergency Action Plan, and this medication permission form are valid for the current school year.

An Emergency Action Plan is required for this medication (to be determined by the school nurse).
❑ Yes ❑ No
Emergency action plan is attached ❑ Yes ❑ No
Date Emergency Action Plan Received by the School: _____

Medication/Prescription Information

❑ Prescription Medication ❑ Over-the-counter Medication provided by parent/guardian
Has the student been given the first dose of this medication? ❑ Yes ❑ No
**The school will not administer the first dose of a medication.
The medication is received in its original container with prescribing information included: ❑ Yes
Name of Medication: _____
Reason for Medication: _____
Form of Medication/Treatment: ❑ Tablet/Capsule ❑ Liquid ❑ Inhaler ❑ Injection
❑ Nebulizer ❑ Other: _____
Time to be given: _____ Dose to be given: _____
If "as needed" indicate the maximum dosage per day: _____
Restriction and/or important side effects: _____
Termination Date: _____

Physician's Information

Prescribing Physician's Name: _____
Phone: _____ Fax: _____

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Parent/Guardian Permission

1. I give permission for _____ (Student's name) to receive the above medication at school.

2. I give district employees permission to contact the student's physician directly to provide information on the Student's condition or to clarify medication administration instructions.

3. I understand that I am **ultimately responsible** for the following:
    a. Providing the school with an adequate supply of medication.
    b. Informing the school district immediately if any information provided on this form changes.
    c. Informing the school if administration of medication should end.
    d. Providing an appropriate Treatment/Emergency Action Plan if necessary.

Signature: _____ Date: _____
Relationship to Student: _____
Home/Cell Phone: _____ Work Phone: _____
Emergency Contact Name: _____ Phone: _____

Notice

Schools in this district are equipped with prefilled epinephrine auto syringes that can be administered in the event of severe allergic reactions that cause anaphylaxis. Epinephrine will be administered only by the school nurse in accordance with written protocols provided by the authorized prescriber, except for the student authorized to carry and self-administer epinephrine in accordance with Board policy.