

OZARK R-VI SCHOOL DISTRICT HEALTH SERVICES

Administration of Medications at School

The Ozark School nurses may administer medications to students during school hours only when necessary to permit the student to attend school and in compliance with the following school policy. We define medication to mean all drugs, including prescription and over-the-counter medication.

If the medication needs to be administered longer than 2 weeks and/or needs to be administered on an ongoing basis throughout the school year a physician's order will be required. If the medication is a prescription the label on the container will act as the Dr.'s order. If the medication is an OVER THE COUNTER medication the Dr.'s request below will need to be filled out by the physician as well as the parent/ guardian will need to also fill out the top portion below. If the medication only needs to be administered for up to 2 weeks only the parent/guardian will need to fill in the top portion of the form below and then will need to pick up the medication 2 weeks from the start date.

Your request will be valid only for the medication and dates indicated in writing on the request form. Requests are valid for a period of one year, but not past the end of this school year.

****ALL medication must be supplied in the original container which is properly marked. Your pharmacist will provide an additional container for prescription medications. Parents/guardian are required to transport all medications.**

If there are extenuating circumstances regarding transportation of medication, please see the building principal.

PARENT MEDICATION REQUEST:

I request and authorize the Ozark School nurse to administer the following medication to the student named below in accordance with the following physician order. I understand that administration of medication may begin when the request is received and reviewed as required by school policy.

Student Name _____

Name of Medication _____ Dose _____

Time Medication is to be given _____ DAILY _____ PRN/as needed _____

Date to start giving medication _____

Date to stop giving medication _____

Reason for medication _____ RX _____ OTC _____

PARENT SIGNATURE _____

DATE _____ HOME PHONE _____ WORK PHONE _____

PHYSICIAN MEDICATION ORDER:

I request and authorize the Ozark school nurse to administer the following medication to the student named in accordance with these written instructions. Such administration is necessary to permit the child to attend school.

Name of Medication _____ Dose _____

Time Medication is to be given _____

Length of prescription _____

PHYSICIAN SIGNATURE _____ DATE _____