Student Name _____ Grade _____

Pulaski County School System
Guidelines for Administration of Medication

The administration of medication by school staff shall be permitted during the school day if it is not possible for the medication to be taken at home or if the prescribing physician specifically states a time during the school day at which the medication is to be given. In the event that medication must be administered to a student during school hours, the guidelines set forth should be followed:

1. Parent/Guardian must sign School Clinic Permission and Guidelines for Administration of Medication forms for any services, including administration of medication, to be seen/treated by the school nurse.

2. Parent/Guardian must sign Authorization for Medication Administration before any long-term medications may be administered or a Short Term Medication Form before any short-term (no more than ten days) may be administered. These forms must be completed at least once a school year or when any medication changes are made.

3. Short-term medications may be prescribed by the doctor and do not have to be given continuously throughout the year or may be over the counter (OTC) medications for a short time only (no more than 10 days), per parent request. Parental permission and administration information is required. This will be presented on a form entitled, Short Term Medication Form. These medications should be brought to the clinic by a parent or guardian and must be in the original labeled container. The parent or guardian must provide the dosage and times to be given. OTC medications will not be given without a physician's order if the amount exceeds the standard dose per bottle. If medication is to be given continuously throughout the year, an Authorization of Medication Administration form must then be completed and signed by a parent/guardian.

4. Long-term medications will be administered every day or as needed throughout the school year and must have an order from the prescribing physician. These medications must also be delivered to the school clinic and an Authorization for Administration of Medication form must be completed and signed by a parent.

5. Under no circumstances will any medication be given that is sent in any container, bag, wrapping, etc., other than the original labeled container.

6. Any over the counter medications that are given on a daily basis for greater than ten school days must have a physician's order.

7. It is the responsibility of the parent/guardian to report to the school nurse any changes in pertinent information regarding student health.

8. Parent/Guardian must immediately notify the school of any changes in medication.

9. All medication will be taken directly to the school nurse by the parent, guardian, or other responsible adult.

10. Students who require the use of prescription Inhaler, Epi-Pen, or Insulin may carry their medication with them, provided the appropriate authorization form is completed and signed by the student and parent/guardian.

11. Students may not carry over the counter or prescription medication on their person, purse or bag. All medication brought to school must be taken to the clinic at the beginning of the school day. An exception will be made for cough drops and throat lozenges.

I have read the above guidelines and agree with the conditions set forth by the Pulaski County School System.

Parent/Guardian Signature: _____ Date: _____

Pulaski County School System
School Clinic Permission Form

Student Information:

Name: _____ Homeroom Teacher: _____

Called Name: _____ Birthdate: _____

Parent/Guardian Information (Please circle person with whom the student resides)

Female Guardian Relationship: _____ Send Mail to this address: _____

Name: _____ Home #: _____ Work #: _____

Address: _____ City/State: _____

Employer: _____ Cell #: _____

Male Guardian Relationship: _____ Send Mail to this address: _____

Name: _____ Home #: _____ Work #: _____

Address: _____ City/State: _____

Employer: _____ Cell #: _____

Siblings: Please list full names of brothers & sisters (including their ages and schools attending)

_____

In the event a parent/guardian cannot be reached, the following people may be contacted with permission to pick up my child from school:

1. _____ Relationship:_____ Phone #: _____
2. _____ Relationship:_____ Phone #: _____
3. _____ Relationship:_____ Phone #: _____
4. _____ Relationship:_____ Phone #: _____
5. _____ Relationship:_____ Phone #: _____

Medical History

Allergies:(_____ None Known) (_____ Yes, they are:_____)

Current Medications: _____

Childhood Diseases

	Yes	No		Yes	No
Chicken Pox	_____	_____	Diabetes	____	____
Measles	_____	_____	Hearing/Vision Impaired	____	____
Mumps	_____	_____	Heart Condition	____	____
Scarlet Fever	_____	_____	Hypertension	____	____
Asthma	_____	_____	Frequent Headaches	____	____
Anemia	_____	_____	Nose Bleeds	____	____
Anxiety/Depression	_____	_____	Kidney/Bladder Problems	____	____
ADD/ADHD	_____	_____	Stomach Problems	____	____
Seizures	_____	_____	Sickle Cell Anemia	____	____

Other: _____

Basic first aid, Vision & hearing Screenings and Scoliosis Screenings are provided by the school nurse. Due to safety issues of the student, the only over the counter medications that will be kept and given, on a limited basis, at school are listed below with reasons to be admistered. Benadryl will be administered according to the manufacture's recommendations based upon age and/or weight. If other over the counter medications or prescription medications are needed, we will be glad to assist with the correct form and medication, provided by the parent/guardian.

YES	NO	Name of Medication	Complaint / Problem
_____	_____	Generic Benadryl	Allergic Reactions
_____	_____	Generic Antacid Tabs	Heartburn
_____	_____	Generic Pepto Bismol	Upset Stomach/Nausea
_____	_____	Acetaminophen 650 mg	Headache/Aches & Pains/Fever
_____	_____	Ibuprofen 400 mg	Menstrual Cramps/Moderate Pains
_____	_____	Generic Tylenol Sinus	Sinus Congestion & Pain
_____	_____	Claritin	Allergies

FOR PARENTAL CONSENT PLEASE SIGN: As parent/guardian of the above noted student, I give Permission for School staff to administer basic first aid, the above checked medications, Vision & Hearing screenings and Scoliosis Screening to my child.

Parent/Guardian Signature: _____ Date: _____