

Bon Homme School District #04 - 2
 School Health Services
Request and Authorization for Medication/Treatment

The following guidelines were established to promote safe adherence to your child's treatment.

Medication given at school:

- A. No prescription or non-prescription medication shall be administered at school by the school secretary or other school designee (determined by the principal) without the following requirements being met:
 1. The medication must be in the original properly labeled container. If it is a prescription medication, the correct name of student, correct name of drug, dosage of drug, time for administering, name of physician, and current date must all be printed on the container. Prescription medication administration will be delegated only to the school office secretary or to those who have successfully completed the training program.
 2. The school must receive written permission from the doctor or dentist to administer the medication.
 3. The school must receive written permission from the parent/guardian to administer the medication.

NOTE: Many pharmacists are willing to "double bottle" (one for the school, one for home) your prescriptions. It is your responsibility to ask your pharmacist to do so.

We encourage medication and treatments be arranged outside of school hours, if possible.

Name of Student _____ Birth Date _____

Allergies _____

Address _____ Telephone _____

Parent/Guardian Name _____ School _____

Parent/Guardian Statement (circle one option)

Option I: I request and authorize personnel at the above named school to supervise the medication/treatment prescribed on this form to my child. I understand the medication must be provided in a bottle, identifying the name and telephone number of the pharmacy, the student's name, physician's name, and dosage of the drug to be taken. I understand that the school district and individuals involved will not be held liable for any adverse effects of the medication.

Option II: I authorize my child to take his/her own medication while at school and relieve the school district and personnel of all responsibility. (Physician's signature not required.)

If you chose this option, please only send a day's dosage with your child. No bottles will be allowed in the lockers.

 Parent/Guardian Signature Date

1. Diagnosis _____
2. Name of medication/treatment _____
3. Total daily dosage _____
4. Amount and time(s) to be administered at school _____
5. Method of administration _____
6. Duration (week, month) _____
7. Precautions and reactions to observe and report _____

 Physician's Signature (Required for Option I) Telephone Date

REQUIRES ANNUAL RENEWAL (Changes may be called to the school secretary by the parent/guardian with written confirmation following within 24 hours)