ST. PAUL LUTHERAN CHURCH & SCHOOL
STUDENT MEDICATION FORM
School Year 2017-2018

This form should be completed only if your child needs to receive a prescription or non-prescription medication at school. **One form per child. This form is to be provided to the School Office**. Information on this form generally will remain within the School Office and may be shared in your child's cumulative file in the school office.

It is the parent's responsibility to notify the School Office of any change in their child's medical status or medication. For proof of immunization and medical history, **each student must have on file an original physician-completed and signed State of Florida Certification of Immunization record (Form 680). For proof of a physical exam, each child shall have on file an original physician-completed and signed State of Florida Student Health Examination (Form 3040).** Parents whose disabled child may need some manner of reasonable accommodation must contact the principal.

Prescribed medications must be in original pharmaceutical containers and dispensed by the school's office personnel. All medications to be dispensed or administered at School must be supported by an Authorization for Administration of Prescription and Non-Prescription Medication form, signed both by the student's physician and parents. Students are not generally allowed to carry non-prescription or prescription medication while at school. The only exceptions are for Epi-Pens, inhalers, and insulin pens, if supported by a physician order and parental consent and the student is mature enough to be responsible for the appropriate administration. Parents who believe self-administration is appropriate for their child should communicate with the principal.

1. Print clearly child's LAST NAME ________________________________ FIRST ________________________________MI __
DOB ____/____/____ CLASS _________

2. Medications. Circle "H" if taken at home or "S" if taken at school.

H S ______________________________ H S ______________________________
H S ______________________________ H S ______________________________

3. Describe any allergies, chronic or serious illness, medical condition(s), concern(s), or limitation(s)
____

4. My child wears/has: ____ glasses ______ contact lenses ____ other medical device

5. Contact Information:

MOTHER	**FATHER**
Last Name, First ______________________	Last Name, First ______________________
Home Phone ______________________	Home Phone ______________________
Work Phone ______________________	Work Phone ______________________
Cell Phone ______________________	Cell Phone ______________________
E-mail Address ______________________	E-mail Address ______________________
LOCAL EMERGENCY CONTACT 1	**LOCAL EMERGENCY CONTACT 2**
Last Name, First ______________________	Last Name, First ______________________
Home Phone ______________________	Home Phone ______________________
Work Phone ______________________	Work Phone ______________________
Cell Phone ______________________	Cell Phone ______________________
Relationship to Child: ______________________	Relationship to Child: ______________________
PRIMARY CARE PHYSICIAN	**___ DENTIST OR ___ OTHER SPECIALIST**
Name ______________________	Name ______________________
Office Phone ______________________	Office Phone ______________________

6. My child is covered by the following 24/7 health insurance policy:
______________________________ (carrier) ______________________________ (policy number)

7. I authorize first aid treatment using basic first aid supplies to be provided to my child as needed. In the event that a parent or emergency contact cannot be reached, I give permission for the School to arrange for necessary medical care. I understand and agree that I will be financially responsible for all aspects of such emergency medical care and I indemnify and hold the school harmless for all damages, claims, and amounts paid or due in connection with such emergency medical care.

______________________________________ ______________
Parent Signature Date

ST. PAUL LUTHERAN CHURCH & SCHOOL
AUTHORIZATION FOR ADMINISTRATION OF PRESCRIPTION AND NON-PRESCRIPTION MEDICATION

(This form is void if altered in any way)

Instructions: This form only needs to be completed and turned in to the school office if your child needs a prescription or non-prescription medication while at school. Each of the three sections must be completed by the appropriate person as follows: Parts I and III by Parent/Guardian; Part II by Physician. Please return the completed form to the School Office.

I. Student Information (to be completed by Parent/Guardian)

Print child's LAST NAME _______________________ FIRST ______________________MI __ DOB ___/___/___ CLASS ______
Parent/Guardian____ Address: ____
Home Phone: _____________________ Work Phone: ________________________ Cell Phone: ______________________________

II. Action Plan (to be completed by Physician). Please complete all spaces.

This request is to be effective for the School Year 20__ - 20__ or earlier stop date: ____
1. Prescription Medication: ____ Generic Name (if used): __________________________
Dosage Amount: ___________________________ Time(s) to be Administered at School: _____________________________________
Condition for Which Drug is to be Given: ____
Note any untoward side effects: ____

Inhalant Prescriptions: This student is both capable and responsible for self-administering this medication:
____ No _____ Yes, if supervised ___ Yes, Unsupervised

2. Non-Prescription Medication: ____________________________________ Generic Name (if used): __________________________
Dosage Amount: ___________________________ Please administer according to manufacturer's label for recommended time schedule when needed at school for the following conditions or symptoms: ____
____

3. Non-Prescription Medication: ____________________________________ Generic Name (if used): __________________________
Dosage Amount: ___________________________ Please administer according to manufacturer's label for recommended time schedule when needed at school for the following conditions or symptoms: ____
____

Print Physician's Name ____________________________________ **Physician's Address:** ________________________________
Physician's Signature: ____________________________________ **Date:** _______________________________

III. Parental Permission (To be completed by Parent/Guardian). Form is void if not completed.

I request the designated school personnel or its agents to assist my child in the administration of the above named prescription and/or non-prescription medications. I give permission for my child to take this medication while in school or while participating in school activities away from the school site. I understand that (1) there is no liability on the part of the school, its personnel, or agents, and hereby release and waive any claims or actions against such persons or entity as the result of the administration of this medication to my child when the person administering the medication acts as an ordinarily reasonably prudent person would have acted under the same or similar circumstances; (2) this mediation must be brought to the school only by a responsible adult; (3) this medication must be in its original labeled container; (4) this medication will be destroyed if it is not picked up within one week following the above stop date or one week after the close of the current school year, or when the medication prescription expires, whichever occurs first. I hereby authorize the exchange of medical information regarding my child's treatment plan between the physician and school health personnel.

____ ____
Parent/Guardian Signature **Date** **Parent/Guardian Signature** **Date**

Medication orders must be renewed by the attending physician and release signed by the parent/guardian annually. Each medication or any change in medication requires a new form. The parent/guardian will be responsible for ensuring that medicines provided for the school have not expired or been recalled.