

Dear Parent/Guardian:

In accord with the policy of the College Community Schools, if medication is to be given by school personnel, we must have written instruction and permission provided by a parent or legal guardian. A form is available at the school office for you to fill out to give this permission. **All** medications must be brought to the school by the parent, guardian, or a responsible adult. **DO NOT** send medication to school with your child.

In addition, the following information is to be clearly labeled on the original bottle from the pharmacy and that original pharmacy bottle is to be left at school.

1. Name of medication
2. Strength, dosage and frequency prescribed
3. Name and address of pharmacy
4. Student's name
5. Physician's name
6. Date of prescription

If the dosage is changed at any time, we **MUST** have a new signed statement from the parent/guardian and doctor indicating the change. The new prescription bottle is acceptable as a statement from the doctor.

Please fill out and sign an authorization for each medication your child is getting. Please do not ask us to give temporary medications, such as antibiotics that are to be given 3 times a day. Such medications can be given at home 1) before school, 2) after school, 3) at bedtime.

No medications will ever be sent home with a student. Parents/guardians must pick up any left over medications when discontinued or at the end of the year.

Thank you,

Kathy Bowersox RN, School Nurse
Phone 848-5225

MEDICATION PERMISSION FORM

Please complete the following form and return to the school office along with the medication in the pharmacy bottle. Please **DO NOT** send medication to school with your student. It is the School Board Policy that medication be brought to school by only the parent, guardian, or responsible adult.

I authorize the school nurse or delegated staff persons at College Community Schools to administer the following medication:

Student Name _____ Grade _____

Medication _____ Strength _____ Dosage _____

At what hour is the dosage given at home? _____ at school? _____

The above medication is to be given until _____

Medication prescribed by _____ M.D.

CONSENT FOR RELEASE OF INFORMATION:

I give permission for the parties named below to exchange written and verbal information with personnel at College Community Schools regarding the above named student. If this medication is for attending or behavior concerns College Community may send behavior checklists to physician named below. This permission is good for one school year.

(Name of physician) phone

Signature: _____
Parent / Legal Guardian daytime phone date

Specific authorization for release of information protected by state or federal law:

My signature releases all information related to (check appropriate spot):

___ Mental Health / Psychological ___ Substance Abuse
___ Other(specify) _____

Note, in order for this information to be released, you must sign here and above:

Signature: _____
Parent / Legal Guardian Date