

## PHYSICIAN PRESCRIBED SERVICES

Dear Parent/Guardian:

We would like to inform you of the policies that have been put in place to ensure the health and safety of students needing medication (including over the counter medication such as Tylenol) during the school day.

A parent/guardian consent form must be completed and submitted to the school nurse before medication can be given. The parent/guardian consent form is enclosed for your convenience. Three choices of dispensing the medication are available.

### Definition of Options:

1. Administration of medication: This involves removing an individual dose from a previously dispensed, labeled container, including a unit dose container; verifying it with the physician's order; giving the individual dose to the student and recording the time and dose.
2. Assistance with self-administration of medication: Means helping a student with one or more steps in the process of taking medication, but not actual administration of medication. This may include opening the medication container, reminding the student of the proper time to take the medication, helping remove the medication from the container, and returning the medication container to the proper storage.
3. Self-administration of medication: The student is responsible for his/her own medication and administration of the medication. It is advised that the student have with them at school the medication needed for the day.

Medication should be delivered to the school in a pharmacy or a manufactured labeled container by the parent/guardian. Please ask your pharmacy to provide separate bottles for school and home. No more than a thirty-day supply of the medicine should be delivered to the school.

When your child needs a medication during the school day, please act quickly to follow these policies to assure that your child's needs are met. Thank you for your cooperation.

Sincerely yours,

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School Nurse

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Telephone

### Parent/Guardian Consent Form Medication Administration/Medical Procedure

Brookings School District # 5-1 Brookings, SD

Student's Name \_\_\_\_\_ School/Year \_\_\_\_\_

Parent's/Guardian's Name \_\_\_\_\_ Telephone no. \_\_\_\_\_

Allergies: \_\_\_\_\_ Reactions: \_\_\_\_\_

**Procedure/treatment:** \_\_\_\_\_

I request and authorize the above procedure/treatment to be implemented for my child at school. I will furnish all the supplies and equipment needed.

Parent's/Guardian's signature \_\_\_\_\_ Date \_\_\_\_\_

**Medication:** \_\_\_\_\_

Dosage/Route \_\_\_\_\_

Time/Frequency \_\_\_\_\_

Side effects \_\_\_\_\_

Reason for the Medication \_\_\_\_\_

Dispensing Options: (Please check your choice)

- \_\_\_\_\_ 1. Administration of medication
- \_\_\_\_\_ 2. Assistance with self-administration of medication

I request and authorize the above medication to be given to my son/daughter at school. I understand the Brookings School District's medication policy and agree to its contents. I will pick up any unused medication the last day of school or within one week of the last dose given or the medication will be destroyed. I give my permission to the school nurse to share information with appropriate school personnel relevant to the prescribed medication.

Parent's/Guardian's signature \_\_\_\_\_ Date \_\_\_\_\_

#### Self-Administration

I authorize my child to self-administer his/her own medication. The Brookings School District will not be held liable.

Parent's Guardian's signature \_\_\_\_\_ Date \_\_\_\_\_