

Goddard School District Medication Policy

Medication Administration Record

I authorize Goddard Schools (USD 265) Administration, Teacher or School Nurse to share information with

Dr. _____ .

Parent Signature: _____ Date: _____

Prescription Medication: It is ideal that all prescribed medications be given by the parent before or after school. However, with a written Physician order, also signed by the parent, a prescribed medication may be given at school by the school nurse or nurse designee. The parent/guardian must have given the initial dose of medication to the child to assure there will be no adverse reaction. The prescription medication must be brought to the school in the original prescription container and parent must ensure the label information contains:

- | | | |
|------------------------|----------------------------------|-----------------------------------|
| *Name of the student | *Name of the medication | *Date the prescription was filled |
| *Prescribing physician | *Medication dose/frequency/route | *Expiration date |

Non-Prescription Medication: Over the counter medications may be administered at school with written parental permission. The medication must be in the original container and the following written instructions must be provided to the nurse/designee:

- | | |
|--------------------------------|---------------------------------------|
| *Name of the student | *Name of the medication |
| *Dosage-how many they can take | *Frequency-how often they can have it |
| *Reason for the medication | *Expiration Date is verified |

School employees who administer the medication in accordance with authorized physician instructions/or parent/guardian instructions and BOE policy shall not be liable for damages resulting from adverse reactions. IN the event of adverse reaction, the student will be treated according to standard emergency care guidelines.

Request to Administer Medication at School:

Student Name: _____ Teacher: _____ Grade: _____

School: Apollo Clark Davidson Earhart Explorer Oak Street Challenger Discovery
 Robert Goddard MS Eisenhower MS Goddard HS Eisenhower HS Goddard Academy

Medication Name: _____

Diagnosis/Reason for taking the Medication: _____

Directions: Dose: _____ (how many) Frequency: _____ (how often)

Duration of Treatment: Current School year Other: _____

Physician Signature: _____ Date: _____
(Required for prescription meds)

Printed Name: _____

Physician Phone Number: _____ Fax Number: _____

Parent Signature: _____ Date: _____
(Required for prescription and non-prescription medications)

Medication Administration Record

Student Name: _____
 Medication: _____
 Dose: _____
 Frequency: _____

Key:
 A = Absent
 F = Field Trip
 ∅ = No med at school
 ✓ = Called parent/sent home for refill
 ISS

	Aug	Sept	Oct	Nov	Dec	Jan	Feb	March	April	May	June
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Supervising RN: _____ Initials: _____ Date: _____
 Delegated Person: _____ Initials: _____ Date: _____
 Delegated Person: _____ Initials: _____ Date: _____