

# Goddard School District Medication Policy

## Diabetic Flow Sheet

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)

