M.S.D. Student Health Services

MNE Fax: 260-569-6838 SCE Fax: 260-569-6841 SES Fax: 260-569-6842
NHS Fax 260-569-6839 SHS Fax: 260-569-6843

LONG TERM PRESCRIPTION or SELF-ADMINISTERED MEDICATIONS

We are aware that there are some circumstances for which a student requires medication during the school hours. However, in compliance with Indiana statues, medication cannot be given unless this form is signed by the legal guardian. The school nurse serves multiple schools and is not available to administer medications every day at each building site. Therefore, each site principal will designate a person to dispense medication, most likely the school secretary. The following guidelines must be followed:

1) All medications must be transported to and from school by parents for students in grades K – 8. Students in grades 9 – 12 may transport only with a parent's signature.

2) Specific directions for medication administration must be in writing and signed by a parent. Directions must clearly specify the condition for which the medication is to be given, time it is to be given, the dosage, and related information.

3) All medications must be in a ***small, original container***. Expiration dates must be current.

4) Medication ***dosage changes must be in writing by the physician***. Physician orders may be faxed to the school.

5) Inhalers must have the pharmacy label on the inhaler also, not just the box.

6) A record of all medication given will be kept by the school nurse and parents are welcome to obtain a copy.

7) This form must accompany each medication brought to school. (Additional forms are available in the school office.)

8) Medication forms are applicable for the current school year only.

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I have read the above and request school personnel to give _____

to _____, _____, _____, on
(name of student) *(date of birth)* *(grade)*

_____ for the following reason: _____
(date/time)

_____

Dosage to be given: _____

List known allergies to medication: _____

Parent/Guardian signature: _____

Date: _____

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Signature of person administering	1st Initial Full last name	Signature of person administering	1st Initial Full last name

PRESCRIPTION RECORD	School Year :	Grade :
Name:	DOB:	Pharmacy:
Medication:	Doctor:	Prescription No.
Dosage:	Route:	Time:
Specific Instructions:		

	1	2	3	4	5	6	7	8	9	10	11	12	13	14	15	16	17	18	19	20	21	22	23	24	25	26	27	28	29	30 31
Aug																														
Sept																														
Oct																														
Nov																														
Dec																														
Jan																														
Feb																														
Mar																														
Apr																														
May																														
June																														

MEDICATION LOG Amount received	**DATE**	**MEDICATION LOG** Amount received	**DATE**	**MEDICATION LOG** Amount received	**DATE**

	DATE
Disposition Depleted	
Discontinue	
Returned	
Destroyed	
Dosage Change	

A = Absent
X = No School
E = Early Dismissal