M.S.D. Student Health Services

LAF Fax: 260-569-6837 **MNE Fax: 260-569-6838** **NHS Fax 260-569-6839**
SCE Fax: 260-569-6841 **SES Fax: 260-569-6842** **SHS Fax: 260-569-6843**

NONPRESCRIPTION & SHORT TERM PRESCRIPTION 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 if needed, most likely the school secretary. Designated staff will always do assessments first (wear glasses, snack, rest, ice pack, etc). 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: ***School Stock Tylenol/Tums/Benadryl (Will Give Age/Wt. Appropriate Dosage, & follow Label Directions***) _____

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

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

_____

_____

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

SHORT TERM PRESCRIPTION RECORD

NAME _____ DATE OF BIRTH _____ GRADE _____

MEDICATION _____

DOSAGE _____ ROUTE _____ TIME _____

SPECIFIC INSTRUCTIONS _____

DATE						
TIME						
REASON						
GIVEN BY						
DATE						
TIME						
REASON						
GIVEN BY						
DATE						
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DATE						
TIME						
REASON						
GIVEN						

MEDICATION LOG

AMOUNT RECEIVED	*DATE*	*AMOUNT RECEIVED*	*DATE*		
_____	_____	_____	_____	Disposition Depleted _____	Date _____
_____	_____	_____	_____	Discontinue _____	Date _____
_____	_____	_____	_____	Returned _____	Date _____
_____	_____	_____	_____	Destroyed _____	Date _____

_____ _____ _____