School_____

Marion County Schools Medication Form

Student Info.

Student Name _____
Last First Middle

Birth Date _____ Homeroom Teacher _____ Grade _____

Medication Allergies _____

Parent/Guardian Name (Print) _____

Parent/Guardian Phone (Preferred) (Secondary)

Physician

THIS SECTION OF THE MEDICATION FORM IS TO BE FILLED OUT BY THE LICENSED PRESCRIBER

Medication orders are valid for the current school year including any summer school programs or extended school year programs. A medication order is required for any prescription and non-prescription (over the counter) medication. If there is any change in medication, dosage, time, or route, a new medication order must be received before the medication can be administered by school personnel. By signing this form, the licensed prescriber is authorizing that this medication may be given at school.

(Use one form for each medication)

Medication _____ Diagnosis _____

Dose _____ Time _____ Route _____

Intended Effect of Medication _____

Potentially Serious Side Effects for this Medication _____

If rectal Diastat/Diazepam or Klonopin is prescribed, may this be administered by unlicensed trained personnel?
Please note that Nasal Versed cannot be delegated to unlicensed personnel ___Yes ___No
May the student self-administer their emergency medication per county policy? ___Yes ___No
May the student carry their emergency medications on him/her per county policy? ___Yes ___No

Name and Title of Licensed Prescriber (**PRINT**) _____
Address _____
Phone _____ Fax _____

Signature of License Prescriber _____ Date _____

Parent/Guardian

Parent/Guardian Authorization

The first dose of the prescribed long-term medication has been given at home? ___Yes ___No **Parent Initial**_____

I understand the following:

*Medication must be brought to school by an adult in the original container and properly labeled with the child's name.
*The licensed prescriber may be contacted concerning the medication order for reasons including, but not limited to, clarification, effectiveness, administration time, dosage, discontinuation, or new medication order.
*Medication administration and procedures may be delegated to school personnel who have been trained by and remain under direct or indirect supervision of the school nurse.
*A photograph of my child may be taken to assist in the correct administration of my child's medication.
*Information may be shared with appropriate school personnel to insure the safety of my student.
*It is the parent/guardian responsibility to replenish long-term and emergency medications as needed and retrieve unused or expired medication from the school. At no time will non-emergency medication be sent home with the student.

I hereby give permission for my child to receive medication at school per the Marion County Schools Medication Policy and as ordered by my child's licensed prescriber. I give permission for appropriate Emergency Action Plan to be distributed to staff. I have read and understand that Marion County Board of Education and its employees are exempt from any liability, except for willful and wanton conduct.

Parent/Guardian Signature _____ **Date**_____

Form Received and Reviewed by School Nurse/RN _____ Date_____
Signature