CEDAR RAPIDS COMMUNITY SCHOOL DISTRICT
MEDICATION ADMINISTRATION PERMISSION FORM

Administration of Medication to Students

Regulation 605.3B of the Cedar Rapids Community Schools Board of Education states: "Only medication prescribed by a legal prescriber** shall be administered during the time the student is at school. A legal prescriber's signature is required for administration of any non-prescription medication, including natural remedies and supplements. The parent or legal guardian shall provide written authorization. The school shall have the right to contact the prescriber's office to confirm or clarify medication instructions. All medication shall be supplied to the school in the original container, properly labeled, and shall be administered only by the school nurse or other personnel who have successfully completed a medication administration course reviewed by the Board of Pharmacy Examiners except students who have demonstrated competency in administering their own medications may self administer their medication with approval of parent/guardian and of the school nurse. A written medication administration record shall be on file at school. All medication shall be stored in a secure area unless an alternate provision is documented. Medication records shall be kept confidential." **** Legal Prescriber – Physician, dentist, podiatrist, licensed physician assistant, advanced registered nurse practitioner.**

- A legal prescriber's signature is required before any non-prescription over the counter medication will be given. (Examples: cough syrup, cough drops, enzymes, herbal remedies, Tylenol, Advil, Etc.)
- The medication must be kept in the Health Office unless the school nurse authorizes otherwise.
- Prescription container labels must include the following information: name of medication, strength and quantity, dosage, prescription serial number, name and address of pharmacy, date prescription is dispensed, time to be given, name of doctor, name of student, and route of administration.
- The time of medication administration may need to be altered slightly to fit your child's schedule. Please remind your child that she/he is responsible to go to the Health Office at the appropriate time.

This form must be completed and returned to the school Health Office for your child to have prescribed medication administered at school.

Name of Student: _____ School: _____ Grade: _____

Name of Medication: _____ Dosage: _____

Prescriber's Name: _____ Prescriber's Signature: _____
(Required for over the counter medications)

Approximate time to be given at school: _____

Give Medication on ☐ Late Start Days Approximate time to be given _____ ☐ Early Dismissal Days Approximate time to be given _____

Length of time medication to be given (if known): _____

Health condition for which medication must be given at school: _____

I request the above student be given this medication at school. The student has experienced no previous side effects from the medication. I further agree that school personnel may contact the prescriber as needed and that medication information may be shared with school personnel who need to know to provide appropriate services to this student.

_____	_____	_____
Parent/Legal Guardian	**Date**	**School Nurse**

If your child is on medication for behavior/attention concerns, you must also sign the Release of Information section below to give your approval for behavior checklists to be submitted to your healthcare provider.

RELEASE OF INFORMATION

I give my permission for exchange of information between school and _____
(Health Care Provider/Facility)

to be of assistance in the medical evaluation of above student for the duration of this school year.

My signature authorizes release of information relating to ☐ mental health ☐ substance abuse ☐ HIV/AIDS

_____	_____
Parent/Legal Guardian Signature	**Date**