MEDICATION ADMINISTRATION FORM

Only medications that are required to enable a student to stay in school may be given at school. Three times a day medication should be given before school, after school, and at bedtime when possible. If necessary, medication can be given at school under the following conditions:

1. MEDICATION MUST BE IN ORIGINAL PROPERLY LABELED CONTAINERS, dated for the current school year and brought to school by an adult. MEDICATION SENT IN PLASTIC BAGS OR UNLABELED CONTAINERS WILL NOT BE GIVEN.
2. Prescription medications will be given only with a specific written request signed by at least one parent/guardian. Physicians must be licensed to practice medicine in the State of Texas. The prescription label will serve as the physician's signature.
3. A trained unlicensed employee may administer medication.
4. All medications must be kept in the Administration Office, except for students whose doctor and parent furnishes the school with a written permit to carry an inhaler or anaphylaxis medication on their person.
5. Please speak to the Dexter Administrator if your child requires long-term medication, any health procedure, or monitoring.
6. Aspirin or products containing aspirin should not be given to students under the age of 18 without a physician's order.
7. FDA APPROVED OVER THE COUNTER MEDICINE REQUIRES PARENT/GUARDIAN WRITTEN PERMISSION AND MAY NOT BE GIVEN LONGER THAN 7 DAYS WITHOUT A DOCTOR'S WRITTEN ORDER.

REQUEST FOR ADMINISTRATION OF MEDICATION AT SCHOOL

Student: ……………………………………………………….. Date: …………………………………

Teacher: ……………………………………………………….. Grade: …………………………………

Medication: …………………………………………………… Dosage: ……………………… Time: ………………..

Medication: …………………………………………………… Dosage: ……………………… Time: ………………..

Parent/Guardian Consent: I give my permission for the above prescription medication(s) to be given to my child at school or on school sponsored field trips. I understand that the medication may be given by an authorized Dexter employee. I consent to and authorize the health care provider to disclose health information to the school, and for the school to disclose the above information to those within the school district that have a need to know for legitimate educational purposes.

Parent/Guardian Signature ………………………………………………………………………………………………

Relationship to Student ………………………………………………….. Phone # ………………………………………………….

Physician Signature ……………………………………………….. Physician Phone # ………………………………..............