School_________________________

Monongalia County Schools Medication Form

Student Information

Student Name ____
Last First Middle

Birth Date ____________________ Age _____ Homeroom Teacher _______________________ Grade ______

Medication Allergies____

Parent/Guardian Name (Print) ____

Parent/Guardian Phone (Home) __________________ (Work) __________________ (Cell) _________________

Physician

This section of the Medication Form is to be filled out by a 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.

Prescribed and Non-Prescribed Medication
(Use one form for each medication)

Medication _____________________________________ Diagnosis/ICD-9 Code ________________________________

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? ___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 this prescribed medication has been given at home? ___ Yes ___ No **Parent Initial** __________

I understand that the medication must be in the original container and properly labeled bearing the child's name.

I understand 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.

I understand that, with due notification of licensed prescriber and parent/guardian, the school nurse/Monongalia County Schools may discontinue medication administration if student's health appears to be at risk.

I understand that 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.

I understand a photograph of my child may be taken to assist in the correct administration of my child's medication.

I hereby give permission for my child to receive medication at school per the Monongalia County Schools Medication Policy and as ordered by my child's licensed prescriber.

Parent/Guardian Signature____ **Date**____________________