

**CARETAKER AUTHORIZATION FOR
ADMINISTRATION OF PRESCRIPTION MEDICATION TO STUDENT**

The undersigned(s) is/are the caretaker(s), parent(s), guardian(s), or person(s) in charge of _____ (“the Student”).

It is necessary that the Student receive _____ (medication), _____ (amount of medication) at _____ (time to be administered), over the counter or physician-prescribed medication, during school intervals beginning on _____ (date) and continuing through _____ (date).

CHECK ONE (1) OF THE FOLLOWING BOXES

_____ I hereby authorize Arlington Public Schools to allow the Student to administer the above-described medication to himself/herself without monitoring or supervision by school personnel.

_____ I hereby request Arlington Public Schools, or its authorized representative, to administer the above-named medication to the Student, in accordance with the prescribing physician’s instructions, and agree to:

1. Submit this request to the principal or school nurse.
2. Make certain the Physician’s Request for the Administration of Prescription Medication by School Personnel is submitted to the principal or school nurse.
3. Make sure personally that the medication is received by the principal or school nurse and/or county nursing services administering it, in the container in which it was dispensed by the prescribing physician or licensed pharmacist.
4. Make sure personally that the container in which the medication is in is marked with the medication name, dosage, interval dosage, and date after which no administration should be given.
5. Submit a REVISED STATEMENT signed by the physician prescribing the medication to the principal or school nurse IF ANY OF THE INFORMATION PROVIDED BY THE PHYSICIAN CHANGES.
6. Provide directions to the school personnel providing the medication.
7. Provide monitoring of the medication's effects, and assume full responsibility therefore.

I understand that unlicensed school personnel may be assigned to provide medication to the Student and hereby release the School District and the Board of Education of the School District and all employees, agents, and representatives of the School District from any liability concerning the providing or non-providing of the medication to the Student.

DATED this _____ day of _____, 20__.

Work Telephone Number

Name of Student

Home Telephone Number

Parent/Guardian

Alternate Number for Parent

Parent/Guardian

(5/11/20)

**PROVISION OF MEDICATION TO STUDENT
PHYSICIAN'S REQUEST FOR ADMINISTRATION OF PRESCRIPTION
MEDICATION BY SCHOOL PERSONNEL**

Date _____

_____ (Student's full name) is under my care and must take medication which I have prescribed during the school day.

Name of medication (as it appears on container in which the medication is stored) _____

Dosage and time _____

Date provision of medication is to begin _____

Date after which the medication should not be provided _____

Possible adverse reactions to be reported to physician _____

Special instructions for the provision and storage of the medication _____

_____ Medication may be self-provided by the student, and the student is competent to self-provide medication, I, or my designee(s), and the student have developed a plan for self-provision of the medication(s), the storage of the medication and a plan for reporting and supervision of self-provision of the medication(s), and deem each to be safe and appropriate, and if applicable authorize the use of hypodermic syringes and needles or similar medical items.

_____ Medication may NOT be self-provided by the student, and the student is NOT competent to self-provide medication, I, or my designee(s), have trained school personnel or approved alternative training as adequate to provide the medication, have evaluated the situation, the storage of the medication, the general administration plan and if applicable, the self-administration plan or emergency care plan, and deem each to be safe and appropriate, and if applicable authorize the use of hypodermic syringes and needles or similar medical items.

Print or Type Name of Physician

Primary Phone Number

Signature of Physician

Secondary Phone Number

REQUEST TO PROVIDE MEDICATION DURING SCHOOL HOURS:

Acetaminophen, Ibuprofen, Cough Drops, Other

IMPORTANT INFORMATION FOR PARENTS/GUARDIANS:

Your written consent is required before your child may receive these medications at school. Please complete the entire form. By signing below, you acknowledge the following:

- You have reviewed the information and agree that your child may safely take the medications in the stated dose.
- The school nurse has the responsibility of approving your child's use of these medications. In the case of a child with special health care needs, the school nurse may request authorization from your physician.
- Your child's medication may be provided by a nurse or by other school personnel determined competent to provide medication as required by Nebraska law.
- In the event your child is ill and school policies require exclusion from school, your child will still be excluded, regardless of use of medication.

PARENTAL CONSENT:

I give my permission to the Arlington Public Schools to administer the following medications to

_____ according to approved guidelines (check if approved)
(child's name/names)

Acetaminophen ("Tylenol") Ibuprofen ("Motrin") Cough Drops

Reason for use: As needed or specify other. _____

Please complete the following:

My child has has not taken acetaminophen before, without problem.

My child has has not taken ibuprofen before, without problem.

Please notify me that day if my child takes any medication. _____

My child is is not taking other medications at this time (please list). _____

It is the parent's responsibility to notify the school if your child has taken any of these medications prior to coming to school.

Special instructions concerning my child: _____

Signature of Parent/Guardian

Date

(5/11/20)

RECORD OF THE PROVISION OF PRESCRIPTION MEDICATION

Parent's Phone # _____
 Name of Student _____ Grade _____
 Medication _____ Date to Begin _____ Date to End _____
 Dosage _____ Time _____
 Doctor _____ Phone #1 _____ Phone #2 _____
 Possible Adverse Reaction: _____

Person(s) Authorized to Administer Medications: _____

Date Provided	Time Provided	Medication Name	Dosage Provided	Route	Refused Medication	Signature of Employee Providing Medication