

**DEER LAKES SCHOOL DISTRICT
Medication Permission Form**

Dear Parent and Physician:

Deer Lakes School District strongly recommends that student medications be administered at home, before or after school. If, under exceptional circumstances, it is absolutely necessary that the medication be given during school hours, the following guidelines must apply:

1. For the safety of your child, students are not permitted to transport or carry with them any medication (over the counter or prescription) at any time. Exceptions to this are outlined below.
2. No medications will be given back to the student to transport home.
3. Prescription medication must be in the original prescription labeled container (you can request a duplicate container from the pharmacist) accompanied by this completed form or a physician written order and a detailed note with parent/guardian signature.
4. Non-Prescription medication must be in the original container with student's name and accompanied by this form or a detailed note, indicating name of medication, dose, and time to give from parent/guardian. The nurse will request a physician's order to administer an over the counter medication.
5. Students who are authorized by a doctor to carry and/or self-administer a medication violate the Alcohol and Other Drugs policy IF he/she permits another student to take or ingest the medication.
6. Any medication not picked up by the last day of school will be disposed of in a non-recoverable manner.

Student's Name _____
Last First Grade

I have read the above information and request that my child be assisted in taking the medicine(s) described below at school by authorized persons or permitted to medicate herself/himself (as outlined below) also by me and my physician. We agree to hold the school, its offices, agents and employees harmless in administering the medication pursuant to the physician's written instructions. We further agree to notify you promptly when it is no longer necessary to administer this medication.



PRESCRIPTION/OVER THE COUNTER MEDICATIONS The PHYSICIAN must complete the following:

Name of Medicine _____ Form _____ Dose _____
Time to be administered _____
Reason for Medication _____
Duration of time medication is required in school: _____
If medicine is to be given "WHEN NEEDED" describe indications: _____
How soon can it be repeated? _____
List significant side effects: _____
Length of time this treatment is recommended _____

PERMISSION TO CARRY AND/OR SELF MEDICATE

Is child authorized to medicate herself/himself? (Ex. Epi Pen or Inhaler) Yes ___ No ___
Student may carry inhaler, epipen (or other) in school or on Field Trips? Yes ___ No ___

Any other necessary information: _____
Physicians Signature: X _____ **Date:** _____
PARENT SIGNATURE: X _____ **DATE:** _____