



The following guidelines outline the procedure necessary for the school nurse or designated school employees to administer non-prescription and prescription medication to children during the school day.

- A. All medication brought to school must be delivered to a school nurse or designated school employee and kept in a secure place, except as provided by terms of Board Policy #5008. Prescription medication must be prescribed for the student and have a pharmacy label attached. All over-the-counter medications must be in their original containers with labeled instructions for administering. Medications will be administered pursuant to the parent's instructions and the directions for use on the label or in the physician's prescription.
- B. A "Parental Authorization Form" must be completed and accompany all medication. The form must give the following information:
  - 1. Name of student.
  - 2. Name of medication.
  - 3. Dosage and special instructions.
  - 4. Date(s) and time(s) medication is to be administered.

The "Parental Authorization Form" must be signed by the student's legal custodian. The authorization will be kept on file in the nurse's office.

- C. In the absence of either the written parental permission form or medication in properly labeled container, no medication will be administered.
- D. Over-the-counter medication which is not designated on the label as appropriate for the child's age will not be administered without written physician authorization.
- E. Any medication requiring administration longer than a two-week period must be accompanied by a physician's written authorization.
- F. A new authorization form must be filled out for each change in dosage of medication or administration.



Las siguientes reglas describen el procedimiento que la enfermera o el empleado asignado de la escuela debe seguir, para poder administrar medicinas recetadas y no recetadas a los niños mientras están en la escuela.

- A. Toda medicina que sea traída a la escuela deberá ser entregada a la Enfermera o al personal designado y deberá ser mantenida en un lugar seguro, exceptuando las situaciones provistas en el manual de Políticas del Comité Escolar #5008. Las medicinas deben de haber sido prescritas para el estudiante, y no a nombre de otra persona, y deben tener un sello de la farmacia donde fueron obtenidas. Todas las demás medicinas que se venden sin recetas médicas, deberán de estar en los frascos originales con las instrucciones para su administración. Los medicamentos serán administrados sólo después de haber sido aprobados por los padres y según las instrucciones médicas o del frasco.
- B. Un papel de “Autorización de los Padres” deberá de acompañar todo medicamento. El papel o formulario deberá tener la siguiente información:
  - 1. Nombre del estudiante.
  - 2. Nombre de la medicina.
  - 3. Dosis e instrucciones específicas de su uso.
  - 4. Fecha(s) y hora(s) cuando se deben administrar.

La “Autorización de los Padres” deberá de estar firmada por los guardianes legales del estudiante. Dicha autorización será mantenida en la oficina de la enfermera de la escuela.

- C. Si no tenemos una autorización por escrito, o si la medicina no está en su frasco original, ningún medicamento será administrado.
- D. Las medicinas sin recetas que no especifiquen en el sello que son apropiadas para la edad del niño(a), tampoco serán administradas sin una prescripción médica.
- E. Cualquier medicamento que requiera ser tomado por más de dos semanas, también deberá de venir acompañado de una prescripción médica.
- F. Si la dosis cambia, o la medicina debe de ser administrada de manera diferente, entonces usted deberá mandar una nueva autorización por escrito.



**Union Public Schools**

**Request for Administration of Medication During School**

NURSE: \_\_\_\_\_ FAX NUMBER: \_\_\_\_\_

STUDENT'S NAME: \_\_\_\_\_ DOB: \_\_\_\_\_

HOME ADDRESS: \_\_\_\_\_ PHONE: \_\_\_\_\_

SCHOOL: \_\_\_\_\_ GRADE: \_\_\_\_\_ TEACHER: \_\_\_\_\_

Dear Parent or Guardian:

Every effort should be made to administer medication at home, as it does represent a disruption in the student's school day. However, if your physician feels that it is necessary, please submit this completed form before medication is sent to school. A new form must be filled out for each change of medication and renewed each school year. School policy does not permit daily administration of medication for longer than two weeks without written directions from the physician and parent.



**TO BE COMPLETED BY PARENT OR GUARDIAN:**

I request the school nurse, principal, or secretary to direct and designate the administration of medication as prescribed below by my physician to my child.

DATE: \_\_\_\_\_ SIGNATURE: \_\_\_\_\_

RELATIONSHIP: \_\_\_\_\_



**TO BE COMPLETED AND SIGNED BY PHYSICIAN:**

STUDENT'S NAME: \_\_\_\_\_

DIAGNOSIS: \_\_\_\_\_

NAME OF MEDICATION: \_\_\_\_\_

DOSAGE AMOUNT TO BE GIVEN: \_\_\_\_\_

TIME TO BE GIVEN: \_\_\_\_\_

DURATION: \_\_\_\_\_

SIDE EFFECTS TO REPORT: \_\_\_\_\_

TO EXPECT: \_\_\_\_\_

COMMENTS: \_\_\_\_\_

DATE: \_\_\_\_\_ PHYSICIAN'S SIGNATURE: \_\_\_\_\_

PHONE: \_\_\_\_\_



Union Public Schools

**Parental Authorization to Administer Medication**

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I hereby give permission to the school nurse or designated school employee to administer medication to my child.

Name of Child: \_\_\_\_\_

Teacher: \_\_\_\_\_ Grade: \_\_\_\_\_

1. Name of medication: \_\_\_\_\_ Dosage: \_\_\_\_\_

2. Name of medication: \_\_\_\_\_ Dosage: \_\_\_\_\_

3. Name of medication: \_\_\_\_\_ Dosage: \_\_\_\_\_

Reason for medication(s) and/or comments: \_\_\_\_\_

\_\_\_\_\_

Time(s) to administer medication(s): \_\_\_\_\_ Date(s) to administer medication (s): \_\_\_\_\_

1. \_\_\_\_\_

2. \_\_\_\_\_

3. \_\_\_\_\_

Name and office telephone number of prescribing physician: \_\_\_\_\_

\_\_\_\_\_

I understand that the school nurse or designated school employee shall not be liable to the student, parent or guardian of the student for civil damages for any personal injuries to the student which result from acts or omissions in administering any medication pursuant to the provisions of Oklahoma House Bill No. 1550, 1984.

\_\_\_\_\_  
Signature of Parent or Legal Guardian

\_\_\_\_\_  
Date

Telephone number of parent/guardian: Home: \_\_\_\_\_ Work: \_\_\_\_\_

**\*\* Please review the medication guidelines on the reverse side of this form. \*\***



Union Public Schools

**Autorizacion de los Padres para Administrar Medicamento**

Yo autorizo y doy permiso a la enfermera de la escuela o empleado designado de la escuela para administrar medicamento a mi niño.

Nombre del Niño: \_\_\_\_\_

Maestro: \_\_\_\_\_ Grado: \_\_\_\_\_

1. Nombre del Medicamento: \_\_\_\_\_ Dosage: \_\_\_\_\_

2. Nombre del Medicamento: \_\_\_\_\_ Dosage: \_\_\_\_\_

3. Nombre del Medicamento: \_\_\_\_\_ Dosage: \_\_\_\_\_

Razones para medicamento y/o comentarios: \_\_\_\_\_

Hora(s) para administrar medicamento especificado: \_\_\_\_\_

Fecha(s) para administrar medicamento especificado: \_\_\_\_\_

Nombre del Doctor de la receta: \_\_\_\_\_

Yo entiendo que la enfermera de la escuela o el empleado designado de la escuela no será responsables al estudiante, padre o guardián del estudiante por daños civiles de ninguna lesión personal al estudiante como resultado de actos o omisión en la administración de cualquier medicamento conforme a las provisiones de Oklahoma House Bill No. 1550, 1984

\_\_\_\_\_  
Firma del Padre of Gurdián legal

\_\_\_\_\_  
Fecha

Numero Teléfono Padre: Casa: \_\_\_\_\_ Trabajo: \_\_\_\_\_

***\*\* Por favor revise las guías en la parte de atrás de esta forma. \*\****