Parental Request Allowing In-School Medication
Hitchcock County Schools

It is the policy of Hitchcock County schools for the School Nurse, Secretary, Administrator, or trained staff members to administer medication to students ONLY with parent or guardian permission and direction. Medications should be given at home if at all possible. **Please complete and return this form for *each* student *every* school year.**

Prescription Medication: All prescription medication must be in the original container in which it was dispensed. The pharmacy label needs to include the prescriber's name, student's name, medication name, dose, route of administration, and times to be given. Prescription medications require an additional form to be filled out by the prescriber and kept on file at school. If your child needs to take daily prescription medication at school, please list medication on this form and also contact the school nurse for the physician authorization form.

Over-the-counter Medication: Over-the-counter medication must be supplied by parents in the original container and labeled with the child's name, type of medication, dose, route, time, and reason to be given(ie: pain, headache, cough, etc). Other medications that are taken only "as needed" should be indicated as such on the back of this form. Please send small bottles of medication, as space is limited. It is acceptable to send one bottle or package for multiple siblings to use. Please label the bottle with each child's name/dose and ensure each child has a form completed.

Peroxide, saline wound cleanser, Neosporin/antibiotic ointment, hydrocortisone cream, calamine lotion, and Benadryl cream are provided in the health office and may be used on minor cuts, scrapes, irritations, and insect bites. Some medications may be available in the office for one-time use by students if consent is indicated.

Any medication that is expired, not properly labeled, or not in its original container will not be given at school. All medication MUST be kept in the health office or school office. No medication will be administered without the completion of this form, or contact with the parent or guardian by school personnel. The school may decline administering medications under certain circumstances. Medications will need to be picked up by an adult by the end of the school year or they will be disposed of.

E*mergency medications such as inhalers, insulin, glucagon, or epi-pens may be kept with the student and self-administered ONLY upon completion of a Self-management at School Consent/Release form AND an Asthma/Anaphylaxis/Diabetes Action Plan. Contact the school nurse for these forms if needed. The school keeps a supply of Epi-pens and Albuterol nebulizers **for unexpected emergencies only**. If your child has a known medical condition, you are responsible for providing your own supply of needed emergency medications.

☐ My child has permission to see the athletic trainer for injuries free of charge if available. A Trainer comes to Trenton every week (as schedule allows) to see students with injuries.

Parent Signature _____ Date_____

Parental Request for In-School Medications
Hitchcock County Schools

Student's Name _____ Birth Date:_____ Grade:_____

Allergic to: _____

I request for the school nurse, secretary, administrator, or approved school staff to see that my child receives the following medication at school. I agree that I will send a supply of all needed medications for this student to use at school. This request is valid for the current school year only.

If no medication is checked or listed below, we cannot give it to your child.

- ☐ Tums or antacid tablet chewed orally every 4 hours as needed for indigestion or upset stomach. Dose: (please check) ____one tablet, ____two tablets
- ☐ Tylenol/acetaminophen, dosed per weight (as directed on package) to be given orally every 4 hours as needed for pain/discomfort/headache. Dose:_____
- ☐ Advil/ibuprofen, dosed per weight (as directed on package) to be given orally every 4 hours as needed for pain/discomfort/headache/inflammation. Dose:_____
- ☐ Cough drops, one lozenge to be given orally every hour as needed for cough/sore throat.
- ☐ Other medication. Medication name: _____ Dose:_____
  Route:_____ Time/frequency:_____ As needed? __Y / N____
  Reason medication is to be given: _____
- ☐ Other medication. Medication name: _____ Dose: _____
  Route: _____ Time/Frequency: _____ As needed? __Y__/ N____
  Reason medication is to be given: _____
- ☐ I prefer to be notified by phone or note sent home if my child receives any dose of "as-needed" medication listed above at school.

-----OR--------

- ☐ I prefer that NO medication be given to my child. Please contact me at the number listed below at any time if my child has health complaints while at school.

1. Parent/Guardian signature: _____Date:_____
Phone number(s):_____

Emergency Contacts if parent/guardian cannot be reached:
2. Name: _____ Phone number: _____
3. Name: _____ Phone number: _____
Doctor's name: _____Clinic:_____ Office phone number:_____

Approval by school nurse _____Date_____