DERBY PUBLIC SCHOOLS
DEPARTMENT OF HEALTH SERVICES
REQUEST FOR ADMINISTERING MEDICATION OR PROCEDURE

Student Name: DOB: Grade:

School: Fax #: HR Teacher/Team:

Parent/Guardian Name: Home #: Work #: Cell #:

Parent/Guardian Name: Home #: Work #: Cell #:

By Board policy, prescription medication is administered at school only upon written request from either a parent or lawful custodian AND a medical person authorized to prescribe medication. Over-The-Counter medication may be administered at school with only a written request from a parent or lawful custodian.

PHYSICIAN OR OTHER LICENSED MEDICAL PERSON'S AUTHORIZATION

Medical condition(s) necessitating medication/treatment: _____

	Medication/Treatment	Dosage/Route	Time/Frequency	Duration of Treatment (ex: school year, days)
1.	_____	_____	_____	_____
2.	_____	_____	_____	_____
3.	_____	_____	_____	_____

Special Instructions: _____

Medical Person's Signature: Printed Name:

Date: Office #: Fax #:

PARENT/GUARDIAN AUTHORIZATION FOR OVER-THE-COUNTER MEDICATIONS

Medication/Treatment	Dosage/Route	Time/Frequency	Duration of Treatment (ex: school year, days)
1. _____	Per package instructions	_____	_____
2. _____	Per package instructions	_____	_____

Parent/Legal Guardian Signature: _____ Date: _____

PARENT REQUEST AND AUTHORIZATION

The medication listed above must be taken during school hours as directed by the health care provider. I grant permission for Derby Public Schools to exchange information with my child's health care provider and dispensing pharmacy identified on the medication label as deemed necessary. The over-the-counter medicine mentioned above needs to be administered as written. I hereby request that the Derby Public Schools cooperate with the prescribing health care provider and assist with the administration of medication pursuant to the policy of the Derby Public Schools. I also certify that my child has received least one dose of the medication requested above and has not had any adverse reactions to it.
I have review the statements on the back and agree to abide by Derby Public Schools School District Policy regarding the administration of medication/procedures at school. I further release Derby Public Schools and school personnel from liability.

Parent/Legal Guardian Signature: _____ Date: _____

School Nurse's Signature: _____ Date: _____

DERBY PUBLIC SCHOOLS MEDICATION PROCEDURES

A. Under certain conditions, the school nurse or nurse-designated person may give prescribed or over-the-counter medication at school. This can be done **ONLY** if the medication is in the **original** container, the original prescription label is affixed, **AND** there is written permission from a parent/guardian **AND** orders from a licensed medical professional if it is a prescription medication. If at all possible, medication should be taken prior to coming to school or after leaving school under parental supervision. Initial dose of medication must be administered by parent/guardian prior to being administered at school. It is the responsibility of the parent/guardian to assure that the medication and dosage in the container is the same as identified on the affixed medication label.
B. School employees who administer the medication in accordance with authorized licensed medical professional instruction, parent/guardian instructions, and BOE Policy (JGFGB) shall not be liable for damages resulting from adverse reactions. In the event of an adverse reaction, the student will be treated according to standard emergency care guidelines.
C. The school staff will only be custodians of medications, and are not to be liable for the child appearing at any specific time to take the medication.
D. A log concerning the dispensing of designated medication will be kept.
E. The parent/guardian MUST submit a written request to the building administrator requesting the school's cooperation in administering the medication and releasing the School District and personnel from liability.
F. Any changes in type of drugs, dosage and/or time of administration shall be accompanied by a new authorization.

Parent/Legal Guardian Signature: _____ Date: _____

School Nurse's Signature: _____ Date: _____