REQUEST TO PROVIDE MEDICATION DURING SCHOOL HOURS
Meridian Public Schools

Important Information For Parents/Guardians:

Your written consent is required **prior** to school personnel providing or administering medication to a child in school. By signing below, you acknowledge the following:

✓ If needed, the prescribing physician may be contacted by the school nurse for clarification on medication administration.
✓ Your child's medication may be given by an unlicensed health technician or by a nurse deemed competent through training or supervision by the Registered School Nurse to provide medication.
✓ The school health office should be notified promptly if there are changes in your child's medication orders.
✓ A physician's (or other licensed prescriber's) authorization is required for medication to be provided at school for all prescription and over-the-counter medication products. The prescriber's authorization may be on the pharmacy label attached to the bottle or, in the case of over-the-counter products, by separate prescription provided to the health office.
✓ All medication products must be sent to the school in the original container with label intact. Medications in bags or any other form of "home packaging" will not be accepted, due to safety considerations.
✓ Parents/guardians are encouraged to provide two weeks' supply of medication.

WRITTEN PARENTAL CONSENT: MUST BE COMPLETED PRIOR TO MEDICATIONS BEING GIVEN AT SCHOOL

I give permission to the Meridian Public Schools to provide _____
(Name of medication and dose)

to _____ at _____ as directed for
(Child's Name) (Approximate Time)

_____.
(Reason for medication)

_____ _____
(Signature of parent/legal guardian) (Date)

CONTACT INFORMATION FOR PARENT/LEGAL GUARDIAN:

_____ _____
(Name) (Phone Numbers)

HEALTH CARE PROVIDER AUTHORIZATION TO ADMINISTER MEDICATION IN SCHOOL

THIS PORTION TO BE COMPLETED BY HEALTH CARE PROVIDER WITH PRESCRIPTIVE AUTHORITY

Child's Name: _____

Medication:_____

Dosage:_____ Route: _____

To be given at the following time(s):_____

Special instructions:

_____

_____

Purpose of medication:

_____

Side effects that need to be reported:

_____

_____

_____

_____

Starting Date: _____ Ending Date: _____

_____

Signature of Health Care Provider with Prescriptive Authority License Number

_____

Phone Number Date