Putnam County Schools
Coordinated School Health Program
Medication Policy

Authorization to Assist Student With Self-Administration of Medication

If a child is required to receive non-prescription or prescription medication during school hours and the parent cannot be at school to administer the medication, **THE PARENT OR GUARDIAN IS RESPONSIBLE FOR DELIVERING (IN PERSON) THE MEDICATION TO THE SCHOOL'S OFFICE.** Only the school nurse, principal, or principal's designee will assist in self-administration of the medication. **ALL MEDICATION MUST BE IN ITS ORIGINAL CONTAINER.**
All **prescription** medication must be brought to school in the original container labeled by the pharmacy, and must include the following information:

- Name of student
- Name of medication
- Dosage
- Administration route and/or other directions
- Date
- Pharmacy name, address, and phone number

All **non-prescription** medication must be brought to school in the original manufacturer's labeled container with the child's name affixed to the container.

Student's Name_____
Teacher/Grade_____

Name of Medication_____
Dosage_____

How medication is to be taken (orally, topically, inhalation, injection)_____

Time or times medication is to be taken_____

Possible side effects, if known_____

Reason medication is needed at school_____

Date or dates medication is to be taken: Start_____ Stop_____

Physician name_____ Physician number_____

I understand that my son/daughter will self-administer the medication with school staff supervision, and I declare that he/she is competent to do so. I will assume full responsibility for any side effects and complications my child may have as a result of taking this medication.

I have read and understand these medication guidelines.

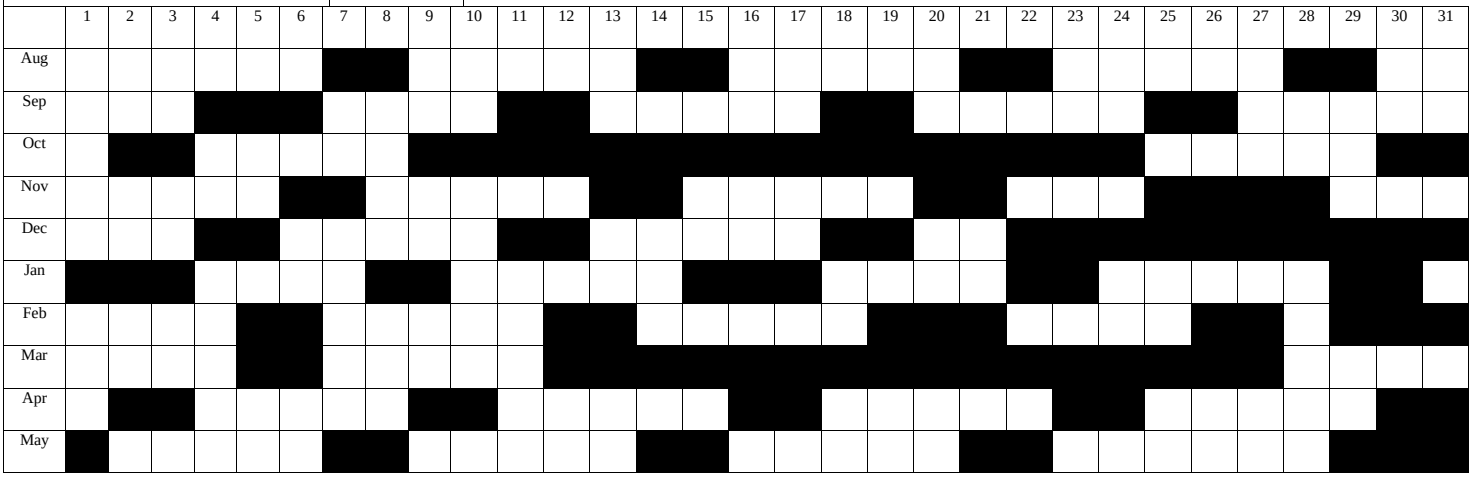
Parent/Guardian's Name (Please Print)
_____

Parent/Guardian's Signature_____
Date_____

Home phone #_____ Work #_____ Emergency #_____

The parent or guardian is responsible for informing the school nurse or the designated official of any change in the student's health or change in medication.

Administered By	Initials



Notes:_____

Date	Pill Count	Parent Signature	School Staff Signature