## CHARITON COMMUNITY SCHOOL DISTRICT

## MEDICATION POLICY AND REQUEST FORM

PLEASE DO NOT SEND ANY MEDICATION TO SCHOOL UNLESS ABSOLUTELY NECESSARY.

**Prescription Drugs** – must be sent in the original bottle with prescription label intact, with name of student, name and strength of drug, amount and time given, date ordered (must be current) and name of doctor. A request form must accompany prescription medication to school and be signed by a doctor and parent.

**Over-the-counter Drugs** – must be sent in the original container, with label and directions intact. Student's name must be on the container. This category includes Tylenol, ibuprofen, ointments, non-prescription eye-drops, etc. A request form must accompany OTC medication to school and be signed by the parent. The school has the right to refuse to give OTC medication if it seems unreasonable, unless accompanied by a note from a doctor. We cannot give medicines to children under 12 if medicine is labeled "Not for children under 12" or if no child's dosage is listed. Aspirin and products containing aspirin will not be given to students without a doctor's order, because of the danger of Reye's Syndrome. Please check the medication label for aspirin content.

**All medications at school** - must be accompanied by a request form with the appropriate Doctor and parent signatures as listed above. Medication not in the original container, or that is not accompanied by a signed request form will not be given. Parents will be required to obtain a school supply of medication. Medication will not be sent back and forth between home and school daily.

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Student Name _____ Grade _____

Medication Name and Strength _____

Amount and Time to be given _____

Dates to be given _____

Asthma Inhaler _____Kept in office and administered by student

_____Kept and administered by student

_____ _____

Physician Signature Date

I absolve the Chariton Community Schools and the person administering the medication of all liability in giving this medication, providing the directions are carefully followed.

_____ _____

Parent Signature Date

FOR SCHOOL USE ONLY

**Long Term Medication Administration Record**

Student Name _____

Medication Name and Strength _____

Amount/Method/Time to be given _____

Physician Name _____

**Person giving medications**

Name _____ Title _____ Initials _____

Name _____ Title _____ Initials _____

Name _____ Title _____ Initials _____

Name _____ Title _____ Initials _____

If given as written above: [X] No School [A] Student Absent [O] Not given, write comments below

| DATE | 1 | 2 | 3 | 4 | 5 | 6 | 7 | 8 | 9 | 10 | 11 | 12 | 13 | 14 | 15 | 16 | 17 | 18 | 19 | 20 | 21 | 22 | 23 | 24 | 25 | 26 | 27 | 28 | 29 | 30 | 31 |
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Comments: _____