MEDICATION ADMINISTRATION

Match Charter Public School requires that the attached form be on file in your child’s health record before we administer any medication at school. The following information must be completed:

1. **Signed medication order form from your child’s healthcare provider.** The healthcare provider order form should be taken to your child’s licensed prescriber (your child’s physician or nurse practitioner) for completion and returned to the School Nurse for BOTH prescription AND over-the-counter medications not already approved by the parent on the student’s Annual Medical Form. **PLEASE NOTE THAT MEDICATION ORDERS MUST BE RENEWED AS NEEDED AND AT THE BEGINNING OF EACH SCHOOL YEAR.**

2. **Signed consent by the parent or guardian.** Please complete the bottom section of the form and sign for medication to be administered to your child during the school day.

Medications must be delivered to the school in a pharmacy or manufacturer-labeled container by you or a responsible adult whom you designate. Please ask your pharmacy to provide separate bottles for school and home. No more than a 30-day supply of medication should be delivered to the school.

If we do not receive the required forms we will NOT be able to administer the medication. Therefore, please promptly follow these requirements so that the School Nurse may begin administering medication to a student as soon as possible.

Thank you for your cooperation.

Sincerely,

Match Nursing Staff
HEALTHCARE PROVIDER ORDER AND PARENT PERMISSION FORM
MEDICATION ADMINISTRATION

Your child’s healthcare provider must fill out this section completely and sign.

Student Name ___________________________ Date of Birth _________________________

Provider Name _______________ Telephone _______________ Emergency Telephone _______________

Date of Order ________________________ Length of Order ________________________

Name of medication ______________________ Dose ________ Route ________

Time to be given at school _______________ Specific Instructions ________________________

Diagnosis(es) ________________________________________________________________

Side effects or contraindications ________________________________________________

Medication allergies ____________________________________________________________

May child self-administer if School Nurse determines that it is safe and appropriate? Yes / No

Physician’s Signature: ___________________________ Date: ___________________________

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Parent/guardian must complete this section and sign. Prescription medication is required to be in its original container with a pharmacy label. Pharmacists can separate the prescription into two bottles, one for home and one for school.

Student’s Homeroom (if applicable) __________

Parent/Guardian Name _______________ Telephone _______________ Emergency telephone _______________

Emergency Contact ___________________________ Telephone ___________________________

Other medications taken by student ___________________________

Any food or drug allergies _________________________________________________

May child self-administer if School Nurse determines that it is safe and appropriate? Yes / No

I give permission to the School Nurse to: (1) delegate or administer medication as prescribed by my child’s healthcare provider, (2) contact the prescriber and share information relevant to the prescribed medication with school staff as he/she determines appropriate for my child’s health and safety, (3) determine if self-administration of medication is safe and appropriate for my
child's health, and (4) dispose of any medications that I have not picked up by the end of the school year or summer academy, as applicable.

Parent/Guardian Signature ___________________________ Date ____________________

**MEDICATION WILL NOT BE ADMINISTERED IN SCHOOL IF MEDICATION POLICIES ARE NOT FOLLOWED**