

# CENTRAL SPRINGS COMMUNITY SCHOOLS

## REQUEST FOR GIVING OUT MEDICATION

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Dear Parent/Guardian:

If you are requesting the school to administer medication to your child, the bottom part of this form **MUST** be filled out and returned to the school.

**The following information must be on the original label from the pharmacy on the ORIGINAL MEDICATION CONTAINER:**

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|---|--|
| 1. name of pupil                            | 4. dosage  |
| 2. name of medication                       | 5. time medication is to be given                |
| 3. name of physician prescribing medication | 6. specific instructions to administer correctly |

Medication that is sent to school in envelopes and plastic bags WILL NOT be administered. Medication **MUST** be sent in the original container. The pharmacist is able to give you an additional bottle if you tell them you need one for school.

Please remind your child that he/she is responsible for asking for the medication at the appropriate time.

This form must be completed and returned to school for your child to have medications administered during school. A copy of the current Board of Education regulation is available. If you have any questions, please call: 641-454-3283 (Manly Campus) or 641-749-5301 (Nora Springs Campus).

As parent (guardian) of a student in the Central Springs Community School District, I hereby authorize and consent to school personnel giving the medication as listed below and release the school district and its personnel from any liability in relation to this request when the medication is given as ordered. I give permission for the school nurse or health official to communicate with teachers about the action and side effects of this medication. I give permission for the school nurse or health official to consult with the named physician regarding any questions that arise with regard to the listed medication or medical condition being treated by this medication. Field trips-I give permission for the assigned teacher/responsible adult to administer the medication on a field trip, as necessary, following school procedure.

### MEDICATION PERMISSION FORM

**Student Name:** \_\_\_\_\_ **Grade:** \_\_\_\_\_

**Medication Name:** \_\_\_\_\_ **Physician:** \_\_\_\_\_

**Prescribed Dosage:** \_\_\_\_\_ **Length of Time Given:** \_\_\_\_\_

**Time to Administer:** \_\_\_\_\_ **Reason for Medication:** \_\_\_\_\_

**Any Specific Instructions or Warnings:** \_\_\_\_\_

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**Parent/ Guardian Signature:** \_\_\_\_\_ **Date:** \_\_\_\_\_