BOWLING GREEN R-I SCHOOL DISTRICT MEDICATION FORM

Phone: 574-324-5441 Fax: 573-324-2439

Name:_____ Date of Birth _____Grade_____

HEALTHCARE PROVIDER COMPLETE THE FOLLOWING INFORMATION

I have prescribed:
Name of medication_____
_____Prescription _____Non-prescription

Treatment of_____

Exact Dosage_____
Circle one: OD BID TID QID

Start Date_____ How long will he/she be taking this?_____

Possible side effects/adverse reactions/precautions_____

The school nurse should notify me if_____

If this is a chronic condition, **(i.e. inhaler, insulin pump, epi-pen)**, do you want the student to self-administer his/her own medication? (NOTE: The student **will not** be supervised by the school). The student **MUST be trained to self-administer** his/her own medication prior to bringing it to school. A note MUST accompany the student from the healthcare provider stating the student has been trained properly on how to administer his/her own medication. Some of the chronic conditions considered by the Bowling Green R-1 District are **Asthma, Diabetes, and Bee Stings. (Self-Administer is for students in grades 6 thru 12 only!!)** Is this student to self-administer his/her own medication? _____yes ____no

Healthcare provider's signature: _____ Date_____

Healthcare provider's name **(printed)**:_____

Healthcare provider's phone number_____Fax Number_____

TO BE COMPLETED BY PARENT/GUARDIAN

I give permission for (name of child)_____
to receive the above medications at school according to standard school policy and procedures.

In order to best serve the interest and health of the students in the Bowling Green R-I School District, the following recommendations should be followed in regard for medication that "needs" to be administered during school hours.

1. If possible medication/s are to be given at **HOME.**
2. When necessary for student to receive medication/s while at school, the medication has to be sent in its **original** container.
3. Medication time is during the student's lunchtime. We will only give medications at another time if specifically requested by the physician.
4. **ALL MEDICATIONS ARE TO BE BROUGHT TO SCHOOL BY THE STUDENT'S PARENT OR RESPONSIBLE ADULT.**
5. I give permission for exchange of verbal and written communication between the physician and the school nurse regarding my child's medication regime while at school.

I have read the statement above and understand

Date:_____Signature:_____Relationship:_____

BOWLING GREEN R-1 SCHOOL DISTRICT

OVER-THE-COUNTER MEDICATION FORM

I give permission for _____

DOB _____ Current Grade _____

to receive the medication listed below at school according to the standard school policy and procedures.

Name of medication _____

Treatment of _____

Exact dosage _____

Start date _____ How long will he/she be taking this _____

The school nurse should notify me if _____

_____

Date _____ Signature _____

Relationship _____

Phone Number _____