SALEM CHRISTIAN ACADEMY, LLC

STUDENT MEDICATION FORM

PART I: PARENT RELEASE FOR DISPENSING PRESCRIPTION/NON-PRESCRIPTION MEDICATION AT SCHOOL - TO BE COMPLETED BY PARENT

(Cough drops are exempt from medical provider approval. Medical form will need to be on file at the office.)

We (I), the undersigned, who are the (CIRCLE ONE): parent(s), foster parent(s), guardian(s) of

_____

Student Name

request that medication be administered to our child in accordance with the instructions of our **Licensed Medical Provider**, _____.

We (I), the undersigned, agree to bring the medication to school in a container from the pharmacist, properly labeled by same. This label shall include name of the student, licensed medical provider, date, dosage instructions (quantity and times), and name of medication.

Further, we (I), the undersigned, will notify the school immediately if we change medical providers or medication or terminate the use of this medication for any reason.

When medication has been discontinued, any remaining mediation must be picked up by the parent within two weeks after discontinuation or it will be discarded by the school nurse. Parent must pick up medication by close of the last day of school or it will be discarded.

I give permission for this information to be sent to the school nurse via facsimile. I also authorize the exchange of information between the licensed medical provider and the school nurse regarding the health care needs of my student when deemed necessary by the school nurse.

SIGNATURE OF PARENT/GUARDIAN:_____ **DATE:**_____

Address:_____

_____

Home Phone:_____ **Work Phone:**_____

**** PLEASE NOTE THAT A LICENSED MEDICAL PROVIDER MUST COMPLETE AND SIGN THE OTHER SIDE OF THIS FORM ****

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Medication for the student listed below cannot be scheduled for other than school hours. The administration of such medication may be supervised by medically untrained personnel. It is requested that the medication as indicated be administered by school personnel. A new form must be provided each school year.

STUDENT NAME:_____ **GRADE:**_____

STUDENT ADDRESS:_____

PART II: MEDICATION TO BE TAKEN -
TO BE COMPLETED BY A LICENSED MEDICAL PROVIDER

Name of Medication:_____

(One Medication Per Form)

Dose:_____ Time to be Given at School:_____

Date Administration is to Begin: _____ End:_____

(End of school year unless otherwise noted)

Possible reactions that, if occur, should be reported to the licensed medical provider:_____

_____

Special instructions if required (administration of drug, sterile conditions and storage, etc.):_____

_____

Name of Licensed Medical Provider:_____

Address of Licensed Medical Provider:_____

Phone Number:_____ Emergency Phone Number:_____

Signature of Licensed Medical Provider:_____

PART III: PERMISSION TO CARRY ASTHMA INHALER/EPI-PEN -
TO BE COMPLETED BY A LICENSED MEDICAL PROVIDER

If requesting permission to carry an inhaler/Epi-Pen, the following section must be completed in addition to PART I. The law permits a student to carry an asthma inhaler/Epi-Pen with the consent of the student's licensed medical provider and parent.

As the prescriber, I have determined that this student is capable of possessing and using this inhaler/Epi-Pen (CIRCLE ONE) appropriately and have provided the student with training in the proper use of the inhaler/Epi-Pen. The student has been instructed to immediately notify a staff member or responsible adult when the Epi-Pen is used.

911 WILL BE CALLED IF THE EPI-PEN IS USED.

Procedures to follow in the event the inhaler /Epi-Pen does not work:_____

_____

Signature of Licensed Medical Provider:_____ **Date:**_____

**** PLEASE NOTE THAT THE PARENTS MUST COMPLETE AND SIGN THE OTHER SIDE OF THIS FORM ****