

# M.S.D. Student Health Services

MNE Fax: 260-569-6838

SCE Fax: 260-569-6841

SES Fax: 260-569-6842

NHS Fax 260-569-6839

SHS Fax: 260-569-6843

## NONPRESCRIPTION & SHORT TERM PRESCRIPTION MEDICATIONS

We are aware that there are some circumstances for which a student requires medication during the school hours. However, in compliance with Indiana statues, medication cannot be given unless this form is signed by the legal guardian. The school nurse serves multiple schools and is not available to administer medications every day at each building site. Therefore, each site principal will designate a person to dispense medication if needed, most likely the school secretary. Designated staff will always do assessments first (wear glasses, snack, rest, ice pack, etc). The following guidelines must be followed:

- 1) All medications must be transported to and from school by parents for students in grades K - 8. Students in grades 9 - 12 may transport only with a parent's signature.
- 2) Specific directions for medication administration must be in writing and signed by a parent. Directions must clearly specify the condition for which the medication is to be given, time it is to be given, the dosage, and related information.
- 3) All medications must be in a small, original container. Expiration dates must be current.
- 4) Medication dosage changes must be in writing by the physician. Physician orders may be faxed to the school.
- 5) Inhalers must have the pharmacy label on the inhaler also, not just the box.
- 6) A record of all medication given will be kept by the school nurse and parents are welcome to obtain a copy.
- 7) This form must accompany each medication brought to school. (Additional forms are available in the school office.)
- 8) Medication forms are applicable for the current school year only.

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I have read the above and request school personnel to give: **School Stock Tylenol/Tums/Benadryl**  
(Will Give Age/Wt. Appropriate Dosage, & follow Label Directions) \_\_\_\_\_

to \_\_\_\_\_, \_\_\_\_\_, \_\_\_\_\_  
(name of student) (date of birth) (grade)

on \_\_\_\_\_ for the following reason: \_\_\_\_\_  
(date/time)

List known allergies to medication: \_\_\_\_\_

Parent/Guardian signature: \_\_\_\_\_ Date: \_\_\_\_\_

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Signature of person administering	1st Initial Full last name	Signature of person administering	1st Initial Full last name

## SHORT TERM PRESCRIPTION RECORD

NAME \_\_\_\_\_ DATE OF BIRTH \_\_\_\_\_ GRADE \_\_\_\_\_  
 MEDICATION \_\_\_\_\_  
 DOSAGE \_\_\_\_\_ ROUTE \_\_\_\_\_ TIME \_\_\_\_\_  
 SPECIFIC INSTRUCTIONS \_\_\_\_\_

DATE						
TIME						
REASON						
GIVEN BY						
DATE						
TIME						
REASON						
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REASON						
GIVEN						

### MEDICATION LOG

<i>AMOUNT RECEIVED</i>	<i>DATE</i>	<i>AMOUNT RECEIVED</i>	<i>DATE</i>	
_____	_____	_____	_____	Disposition Depleted _____ Date _____
_____	_____	_____	_____	Discontinued _____ Date _____
_____	_____	_____	_____	Returned _____ Date _____
_____	_____	_____	_____	Destroyed _____ Date _____