USD 353 WELLINGTON, KANSAS
ANNUAL STUDENT MEDICATION ORDER/RELEASE
SCHOOL YEAR _____ - _____

Top Section is to Be Completed By Health Care Provider: MD, DO, ARNP or PA for most medications &/or procedures; Dentist/Orthodontist - dental needs; Optometrist/Ophthalmologist – eye medications.

_____ _____ _____
Name of student to receive medication/procedure **Date of Birth** **Grade**

Name of Medication: _____

Specific dose and time: _____

Reason for Medication: _____

Medication is to be taken to school sponsored events/activities: Yes____ No____

Medication is to be maintained and administered by school personnel only: Yes _____ No_____

******USD 353 Policy states that students are not to carry prescription or nonprescription medications in school unless they fall into the Self-Administration category as outlined below.******

Self-Administered Medications: **Asthma Inhalers** for Respiratory Needs; **Epinephrine-pen** for Allergic Reactions; **Insulin/Glucose supplement/Glucagon** for Diabetes; may be prescribed for students in the KG-12th Grades. The Health Care Provider and Parent/Guardian must give permission, and attest to the student's ability to self-administer the medication.
I the undersigned health care provider hereby give my permission for the above named student to self-administer his/her medication as written above. This student has been instructed on and is competent in the self-administration of the medication and is authorized to do so at school and school sponsored events.

Self-Administration of Medication (asthma inhaler, epinephrine-pen) (insulin- is usually kept in Nurse office due to borne pathogens &/or sharps disposal issues &/or need for refrigeration of the insulin):

Keep in Health Room only	YES____	NO____
Student is to take medication to events/activities	YES____	NO____
Student is to carry medication at all times	YES____	NO____

_____ _____
Signature of Health Care Provider **Health Care Provider's Name Printed**

_____ _____ _____
Date **Phone #** **Fax #**

Section below must be Completed & Signed by the Student's PARENT/GUARDIAN

I grant permission for the School Nurse or a delegated staff member to administer medication/treatment to my Child/Student at school as indicated by the Health Care Provider in the above section. I understand that I must provide any medication in its original labeled container. I must also provide any other supplies needed to comply with the order written above. I agree with the medication/procedure as identified above & self-administration of medication if ordered above. I also acknowledge the need and give permission for appropriate communications between the School Nurse and the Health Care Provider identified above related to the specific treatment in question, communication may include: 1. The prescription or treatment itself (e.g., questions regarding dosage, method of administration, potential drug interactions, size of catheter for emergency insertion in the track of a dislodged gastrostomy tube, etc.); 2. Implementation of the treatment in school (e.g., questions regarding safety concerns, infection control issues, or modifications in the treatment order related to the school setting or student's academic schedule); 3. Student outcomes from the treatment (e.g., questions regarding observed side effects, possible untoward reactions, observations of behavior changes in the classroom); 4. Other pertinent issues related to the student's diagnosis, condition, or treatment.

_____ _____
Signature of Parent/Guardian Home Phone #

_____ _____
Print Name Daytime/Work/Cell Phone #'s

Return completed order/permission sheet with the medication, in it's original container, to the Office of the School in which your child/ student is enrolled. **(revised: 11/2004, 5/12/2005, 7/2010, 4/2012, 5/2013)**