Proud Traditions ... Unlimited Possibilities
Indianola Community Schools

Request for Giving Prescription and Nonprescription Medication at School

Student's Name: Grade: Birthdate:

School medications and health care services are administered following these guidelines:

- Parent/Guardian signed and dated authorization to administer the medication.
- The medication must be in the prescription container or the container in which it was purchased.
- The medication label contains the student name, name of the medication, directions for use and date.
- Annual renewal of authorization and immediate notification, in writing, of changes.

Permission for Over-the-Counter (Medications that are provided by the school)

Yes ☐	No ☐	Acetaminophen (Tylenol)—according to package directions
Yes ☐	No ☐	Ibuprofen (Motrin, Advil)—according to package directions
Yes ☐	No ☐	Cough drops—according to package directions
Yes ☐	No ☐	Antacid tablets
Yes ☐		Other .

Permission for Prescription Medications (The medication must be in its original container)

Name of Medication: _____

Medication Dosage: _____

Dates to be Given: _____

Time to be Given: _____

Doctor Who Prescribed Medication: _____

Additional Information or Administration Instructions: _____

I request the above student be given the medication at school by qualified staff, according to the prescription or nonprescription instructions, and a record maintained. The student has experienced no previous side effects from the medication. I further agree that school personnel may contact the doctor/prescriber as needed and that medication information may be shared with school personnel who need to know.

I understand the law provides that there shall be no liability for civil damages as a result of the administration of medication where the person administering the medication acts as an ordinarily reasonably, prudent person under the same or similar circumstances. I agree to provide safe delivery of medication and equipment to and from school and to pick up remaining medication and equipment.

_____ _____

Parent/Guardian Signature **Date**

☐ By checking this box, I acknowledge this is my legal signature

For more information refer to School Board Policy # 507.2 at www.indianola.k12.ia.us.

Medication Reconciliation

Date	Doses Provided	Doses Returned	Location	Initials / Staff

Medication Reconciliation Done

	Aug	Sept	Oct	Nov	Dec	Jan	Feb	Mar	Apr	May	Jun
Date											
Initials											

Communication for end of year medication disposal

- ☐ Letter
- ☐ Email

Date: _____