Student Name: _____ DOB:_____

MEDICATION POLICY

A. All medication must be in original container and not past expiration date.
B. Written permission is required from physician and parent/guardian.
C. All medications are to be carried to and from school by parent/guardian.
D. All medications will be counted when delivered to and released from health services staff to parent/guardian.
E. All prescription medications must be properly labeled in the original container.
F. No medications will be given that is NOT FDA approved.
G. Staff shall not administer medication that exceeds recommended maximum dosage in the Physician' Desk Reference.
H. All requests are for current school year only.
I. Non-prescription (or over-the-counter) medication will be given for only 5 consecutive days in one (1) calendar school year. If needed over 5 days a physician's note will be required.
J. For herbal or dietary supplements, please refer to Legal and Local policy for Red Oak I.S.D.

I hereby request and authorize Red Oak I.S.D. health services to dispense and/or monitor the medication or treatment prescribed by my child's physician. I understand that neither the person administering the medication nor Red Oak I.S.D. will be held responsible or liable for any side effects or problems from the medication.
I am giving permission for Red Oak I.S.D. staff to contact the physician for additional information, if needed.
I understand all medications are to be carried to and from the school by parent/guardian.

NAME OF MEDICATION: _____

INSTRUCTIONS:_____

_____

_____

_____ _____ _____ _____

physician signature **date** **parent/guardian signature** **date**

MEDICATION COUNT **DATE:** _____ **COUNT :** _____ **INITIAL:**_____	**MEDICATION COUNT** **DATE:**_____ **COUNT :**_____ **INITIAL:**_____	**MEDICATION COUNT** **DATE:** _____ **COUNT:**_____ **INITIAL:**_____	**MEDICATION COUNT** **DATE:**_____ **COUNT:**_____ **INITIAL:**_____
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