ADMINISTRATION OF MEDICATION TO STUDENTS H4

All medications (whether prescription or over the counter) shall be brought to school by parent/guardians and shall be picked up at the end of the period of medication or end of school year.

Primary Prep Elementary and Play & Learn shall not be responsible for any diagnosis and treatment of pupil illness. The administration of medication to a pupil during school hours will be permitted only when failure to take such medicine would jeopardize the health of the pupil, or the pupil would not be able to attend school if the medicine were not made available to him/her during school hours. For purposed of this policy, medication" shall include all medicines **prescribed** by a physician for the particular student, including emergency medication in the event of bee stings, etc., and all over the counter medications. Before any pupil during may administer to or any medication school hours, Primary Prep Elementary and Play & Learn and its employees of liability for administration of medication. In addition, Primary Prep Elementary and Play & Learn required the written order of the physician (even for over the counter medication), which shall include:

A. Name of EACH Medication
B. The purpose of EACH Medication
C. The dosage of EACH Medication
D. The time which or he special circumstances under which EACH Medication shall be administered
E. The length of time for which EACH medication is to be taken. The release must be renewed by the Physician and parents **yearly**,
F. The possible side effects of EACH medication.

NAME:_____DOB:_____WEIGHT:_____

DIAGNOSIS:_____

If oral medications are ordered to be given prior to or in conjunction with an EPI-PEN, list the medication in the exact order they are to be given;
#1 being the FIRST MEDICATION to be administered.

#1 MEDICATION:_____DOSAGE_____FREQUENCY/TIME_____

#2 MEDICATION:_____DOSAGE_____FREQUENCY/TIME_____

#3 MEDICATION:_____DOSAGE_____FREQUENCY/TIME_____

POSSIBLE SIDE EFFECTS OF MEDICATION
#1_____
#2_____
#3_____

The school nurse has permission to administer the above medication as prescribed.

PHYSICIAN'S SIGNATURE: _____
PHYSICIAN NAME: _____
ADDRESS: _____
CITY, STATE, ZIP _____

DATE: _____PHONE NUMBER:_____

PARENT'S SIGNATURE:_____

DATE:_____PHONE NUMBER:_____

SCHOOL NURSE SIGNATURE:_____DATE:_____

PRINCIPAL SIGNATURE:_____DATE:_____

NO FAXES ACCEPTED FOR LEGAL DOCUMENTS