

**Jefferson C-123 School District**  
Parental permission for medication administration to student

The Jefferson C-123 school district medication administration policy requires written parental/guardian consent prior to giving any prescription and/or over the counter medications at school.

Please provide the following information when bringing medication to be administered at school.

**IMPORTANT:**

- \*This form is to be presented to the nurse/or principal's office for each medication that is to be given.
- \*If the medication is a prescription, please ask your pharmacist to prepare two (2) labeled containers, one for school, and one for home.
- \*The very first dose of ANY medication may NOT be given at school.
- \*All medications must be transported to and from school by the parent or adult in charge!

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Student Name: \_\_\_\_\_ Grade: \_\_\_\_\_

Name of medication: \_\_\_\_\_ Dosage: \_\_\_\_\_

Form of medication/treatment: Tablet/capsule \_\_\_ Liquid \_\_\_ Inhaler \_\_\_ Injection \_\_\_ Other \_\_\_

Time of day to be taken: \_\_\_\_\_

Reason for medication: \_\_\_\_\_

Medication to be given from: \_\_\_/\_\_\_/\_\_\_ to \_\_\_/\_\_\_/\_\_\_

Refrigeration needed? Y N

When was the first dose of this medication given? \_\_\_/\_\_\_/\_\_\_

Any special directions, or possible side effects to watch for: \_\_\_\_\_  
\_\_\_\_\_

\*\*\*\*\*

I am requesting the school nurse or designated school personnel to administer the medication prescribed by:

\_\_\_\_\_ to \_\_\_\_\_  
Licensed prescriber student

I request the above medication or treatment to be administered to my child at school. I understand that I have the ultimate responsibility for providing the school an adequate supply of medication and for informing the school district immediately if any information on this form changes.

Parent/guardian: \_\_\_\_\_ Date: \_\_\_\_\_

**Medication Administration Daily Log**  
(To be completed for each medication)

School Year \_\_\_\_\_  
 Name of Student \_\_\_\_\_ Date of Birth \_\_\_\_\_ Sex \_\_\_\_\_ Grade/Home Room (or Teacher) \_\_\_\_\_  
 Name of School \_\_\_\_\_ Name of Dispensing Pharmacy \_\_\_\_\_ Frequency \_\_\_\_\_ Times(s) Given in School \_\_\_\_\_ RX # \_\_\_\_\_  
 Name and Dosage of Medication \_\_\_\_\_ Route \_\_\_\_\_

Directions: Initial with time of administration; a complete signature and initials of each person administering medications should be included below.

	1	2	3	4	5	6	7	8	9	10	11	12	13	14	15	16	17	18	19	20	21	22	23	24	25	26	27	28	29	30	31	
Aug																																
Sept																																
Oct																																
Nov																																
Dec																																
Jan																																
Feb																																
Mar																																
Apr																																
May																																
June																																

NOTE: Person administering medication should initial and sign below.

- INITIAL SIGNATURE INITIAL SIGNATURE INITIAL SIGNATURE INITIAL SIGNATURE INITIAL SIGNATURE INITIAL SIGNATURE INITIAL SIGNATURE INITIAL SIGNATURE
- \_\_\_\_\_ 5. \_\_\_\_\_
  - \_\_\_\_\_ 6. \_\_\_\_\_
  - \_\_\_\_\_ 7. \_\_\_\_\_
  - \_\_\_\_\_ 8. \_\_\_\_\_
- A) Absent (O) No Show  
 E) Early Dismissal (W) Dosage Withheld  
 F) Field Trip (X) No School (i.e., holiday, weekend, snow day etc.)  
 N) No Medication Available

Use reverse side for reporting significant information (e.g. observations of medication's effectiveness, adverse reactions, reason for omission, plan to prevent future "no-shows").