



Raymore-Peculiar School District

P. O. Box 789, Peculiar, MO 64078

MEDICATION ORDER AND CONSENT FORM 2019-2020

STUDENT _____ GRADE _____ SCHOOL _____ FAX _____

K-12 PARENT/LEGAL GUARDIAN: Please INITIAL one or more of the listed non-prescription, school-owned medications as appropriate for your child and authorize administration with signature below. Medications will be administered in accordance with school policy.

- _____ **Acetaminophen** (like Tylenol) titrate dosage by age/weight for pain or temperature
- _____ **Antacid** (like Tums) for the relief of stomach indigestion
- _____ **Anti-Itch Lotion** (like Caladryl) apply topically for itching or insect bites
- _____ **Throat Spray** (like Chloraseptic) for sore throat/tooth numbness
- _____ **Triple Antibiotic Ointment** (like Neosporin) for minor cuts, scrapes and burns
- _____ **Camphophenique Liquid** for fever blisters, cold sores or insect bites
- _____ **Sterile Saline Solution** for flushing of eyes
- _____ **Cough Drops** (for K-5 to be consumed in the health room)
- _____ ****FOR EMERGENCY USE ONLY – 1 time dose (titrate dose based on weight) – Diphenhydramine (Benadryl) for hives/allergic reaction – NOT for seasonal allergies**
- _____ **Ibuprofen** - titrate dosage by age/weight for pain or temperature (1-2 tablets)

AUTHORIZATION:

I hereby give permission for my child to receive the non-prescription, school-owned medications indicated above as deemed necessary by the school nurse or designated personnel. I understand that the Raymore-Peculiar School District, and its representatives, administering medications according to order and proper dosage, shall not be held liable for damages as a result of any adverse reaction. I also authorize the school nurse to contact the student's Authorized Prescriber/Primary Care Provider regarding any written order.

Parent/Legal Guardian _____ Date _____

DO NOT AUTHORIZE:

I do not give permission for my child to receive the medications indicated above at school. However, I authorize the school nurse to contact the student's Authorized Prescriber/Primary Care Provider regarding any written order.

Parent/Legal Guardian _____ Date _____

Authorized Prescriber/PRIMARY CARE PROVIDER: Prescription medication and non-prescription, non-school-owned medication brought from home and required for administration during school hours:

RX: _____
(Please include Drug Name, dosage, time and duration of administration)

NON RX: _____

Diagnosis: _____

Authorized Prescriber/Primary Care Provider **PRINTED** Name _____ **Signature** _____
 MD DO FNP ANP PA DDS Office Phone _____ Date _____

PARENT/LEGAL GUARDIAN CONSENT:

I hereby give permission for my child to receive the prescribed medications and non-prescription, non-school-owned medications indicated as deemed necessary by the school nurse or designee. I understand that I have the ultimate responsibility for providing the school with an adequate supply of medication(s) and for informing the school district immediately if any information provided on this form changes, or if administration of medication(s) should cease. I understand that the Raymore-Peculiar School District, and its representatives, administering medications according to order and proper dosage, shall not be held liable for damages as a result of any adverse reaction. I also authorize the school nurse to contact the student's Authorized Prescriber/Primary Care Provider regarding any written order.

Parent/Legal Guardian _____ Date _____