Raymore-Peculiar School District

P. O. Box 789, Peculiar, MO 64078

MEDICATION ORDER AND CONSENT FORM 2018-2019

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) – **Diphenydramine (Benedryl)** for hives/allergic reaction – **NOT** for seasonal allergies

FOR GRADES 6-12 ONLY:

_____ **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_____