

MCS Medication Authorization Policy

If it is necessary that a Prescription medication be given during school hours, the following regulations must be followed.

- Medication authorization form to be filled out completely.
- Parent or guardian is required to bring medication to school.
- Only medications prescribed by a physician will be given. - All medication must be in the current pharmacy labeled container, and include the following information:
 - ✓ Student's name
 - ✓ Directions for administration
 - ✓ Physician's name
- Authorization for medication is effective for the length of time prescribed, and no longer than the current school year.
- The school nurse will dispense medication
- No student shall have in his/her possession any medication while on school property. Inhalers and epi-pens are an exception to this rule.
 - Inhalers may be self-administered if prior authorization by his/her physician has been provided to the school.
 - Epi-pens may be self administered or given by any school personnel trained to administer Epi-pens. The school requires advanced notification (authorization from a physician) for all children who may need access to an epi-pen.

If the student will be on a field trip, or other school supported event—a medication plan will be developed and agreed to by the parent, physician and school administration.

MCS

**Authorization for Medications to be Taken During School Hours
(PHARMACY - LABELED CONTAINERS ONLY)**

School Grade/Teacher _____ Date _____

Child's
Name _____
Last First Sex Date of Birth

Physician's Name: _____

Address _____ Telephone _____

The following section is to be completed by the PARENT: I request that my child be assisted in taking the medicine(s) described below at school by the school-nurse teacher or permitted to medicate herself/himself as also authorized by me and my physician - *see below.

Parent/Guardian
Signature: _____ Date: _____

Home Phone Emergency Phone _____

The following is to be completed by the PHYSICIAN:

Diagnosis for which medication is prescribed: _____

Name of medicine: _____ Dose _____

If medicine is to be give DAILY, at what time(s)? _____

If medicine is to be given "WHEN NEEDED", describe indications:

How soon can it be repeated? _____

List significant side effects _____

Length of time this treatment is recommended? _____

*Is child authorized to medicate herself/himself? _____

Self-medication applied only to inhalers, Epi-Pens and prescribed self-injected medication.

Other information _____

Physician's
Signature _____ Date: _____