

MEDICATION AGREEMENT

TO BE COMPLETED BY SCHOOL:

School _____ Teacher _____ Student # _____

TO BE COMPLETED BY PARENT OR GUARDIAN

I hereby request and give my permission to the Jefferson County School District R-1 to administer medication to my child. I understand that it is my responsibility to provide the medication in the original pharmacy labeled container. I also understand the school may not alter or change any medications from their original form (cut or half pills, etc.)

Any prescription changes will require an additional signed and completed Medication Agreement

Name of Student _____ Birthdate _____

Medicaid No Yes Medicaid # _____ Social Security Number ____ - ____ - ____

Parent's Name _____ Phone H: _____ W: _____

Medication: _____ Dosage: _____ Time: _____

Continuous From _____ to _____

Signature of Parent or Guardian Date

TO BE COMPLETED BY PHYSICIAN (FOR PRESCRIPTION)

Patient's Name _____ Medicaid # _____

Medication _____ Purpose _____

Dosage _____ Times(s) be be given at school _____

Continuous From _____ To _____ Possible side effects _____

Name of Physician _____ Office Telephone _____

FAX _____

Signature of Physician Date

Only school employees who are trained and delegated to may give medications. The person giving the medication must put their initials and time they gave medication in the appropriate box.

Delegated by _____

Initials	Persons Dispensing Medication	Title	Delegated Date
_____	_____	_____	_____
_____	_____	_____	_____
_____	_____	_____	_____
_____	_____	_____	_____
_____	_____	_____	_____
_____	_____	_____	_____

SUPPLEMENTAL MEDICATION LOG

Attach to the completed Medication Agreement (Form #924) for this medication

Student Name _____ Medication: _____

Student ID _____ Medicaid # _____ Dose #1: Time _____

Student Birthday _____ ICD9 _____ Dose #2: Time _____

Are you dispensing other medication(s) to this student? No Yes (How many? _____ What times? _____)

Abbreviations: AB=Absent FT=Field Trip NS=No Show SO=School Out (i.e. Holiday) SR=Student Refused



MONTH:		YEAR:				
Week 1	Mon	Tue	Wed	Thu	Fri	
Date						
Dose #1	Time					
	Initial					
Dose #2	Time					
	Initial					

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Week 1	Mon	Tue	Wed	Thu	Fri	
Date						
Dose #1	Time					
	Initial					
Dose #2	Time					
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Week 1	Mon	Tue	Wed	Thu	Fri	
Date						
Dose #1	Time					
	Initial					
Dose #2	Time					
	Initial					

Signature

RN _____ Date _____

Signature

RN _____ Date _____

Signature

RN _____ Date _____