Dear Parents/Guardians:

As a courtesy and help for your child to succeed in school, we are happy to dispense medication during school hours. Below is our policy regarding dispensing medication during school hours and a permission form for completion.

- **Prescribed Medication:** A physician and parent/guardian must complete our permission form. *Medication cannot be dispensed without the completed form.* If a prescription changes, a new form will need to be completed.

- **Current Prescription:** Medication must be in a current prescription bottle. Some physicians will write the prescription so that the medication is split into two bottles by the pharmacist. We will not dispense medications in an outdated bottle. You will need to come to school and pick up outdated medication.

- **Splitting Pills:** School personnel are not responsible for splitting pills. Please be sure the prescription and/or pharmacy supply you with the exact dosage or split them before bringing them to school. For example, if your child takes 5mg of a medication, we will not split 10mg pills at school.

- **Non-Prescribed Medication (ex. Advil, cough syrup, topical creams):** All medication must have a permission form* completed by the parent. *We cannot dispense any medication without the permission form.* A letter from home will not fulfill this requirement.

- **Reminders:** Your child will be reminded when they forget to take medication at the prescribed time. We cannot give the medication more than one hour late. If this occurs, you will be contacted either by telephone or note.

  **ALL MEDICATION WILL BE DISCARDED IF NOT PICKED UP BY A PARENT/GUARDIAN BY THE LAST DAY OF THE SCHOOL YEAR.**

*Additional Medication Permission forms are available in the school office. The completed form may be faxed to at 616-364-9140 for KCTC, KIH and MySchool at Kent or to 616-365-2225 for KTC.

**THIS POLICY IS IN PLACE TO ENSURE CHILD SAFETY.**

Thank you for your cooperation and support!
Kent ISD Secondary Campus

Student Medication Authorization Form

(Required when a student needs to take a prescription and/or non-prescription medication to be taken at school.)

______________________ __________________ _____________________ ________
Student’s Name   Birth Date  School    Date

School medications and health care services are administered following these guidelines:

☐ Physician/prescriber signed and dated authorization to administer the medication
☐ Parent/guardian signed and dated authorization to administer the medication
☐ The medication must be in the original labeled container as dispensed or the manufacturer’s labeled container
☐ The medication label must contain the student’s name, name of the medication and directions for use and date
☐ Annual renewal of authorization and immediate notification of changes is required.

Physician Authorization:

___________________________ ______________________ ____________________
Medication/Treatment   Dosage     Time to be Administered

________________________________________________________________________________
Intended Effect of Medication/Treatment    Side Effects (if any)
________________________________________________________________________________

Other Medication the Student is Taking

May the student self-administer the medication under the supervision of a school nurse or school designee?  ________________ Yes  ________________ No

Administration Instructions:

___________________________________________________________________________________
___________________________________________________________________________________

Date to Discontinue, Reevaluate or Follow Up:

___________________________________________________________________________________

Physician’s Signature         Date Signed

______________________________________        __________________________________________
Physician’s Name:         Printed

______________________________________        __________________________________________
Physician’s Emergency Phone Number       Physician’s Address
**Parent Authorization:**

I acknowledge that I am primarily responsible for administering medication to my child. In the event that I am unable to do so or in the event of a medical emergency, I authorize Kent ISD and its employees and agents, on my behalf and stead, to administer or to attempt to administer to my child or to allow my child to self-administer while under the supervision of an employee or agent of Kent ISD, lawfully prescribed medication in the manner described above. I acknowledge that it may be necessary for the administration of medication to my child to be performed by an individual other than a school nurse and I specifically consent to such practices. I further acknowledge and agree that when lawfully-prescribed medication is so administered or attempted to be administered, I waive any claims that I might have against Kent ISD, its employees and agents arising out of the administration of said medication.

________________________________________        __________________________________________
Parent’s Signature                                           Date Signed

________________________________________
Parent’s Phone Number

________________________________________
Parent’s Emergency Phone Number

Additional Information:

_____________________________________________________________________________________

_____________________________________________________________________________________
Kent ISD Secondary Campus

Authorization for Student Self- Medication Form

(Required if student has authorization to self-administer asthma medication and/or an Epinephrine Auto-Injector)

School Year: __________________________

Student’s Name: __________________________   Birth Date: __________________________

School: ___________________________________________________________________________

Physician, Physician Assistant or Advanced Practice RN Authorization

I certify that this student has been instructed in the use and self-administration of their emergency asthma medication and/or Epinephrine auto-injector (or EpiPen). He/she understands the need for the medication and the necessity to report to school personnel any utilization of the medication and/or any unusual side effects. He/she has been given instructions and is capable of using this medication independently.

1. Will this student self-carry medication? ____________Yes ____________No

2. Will a second set of medication be kept in the health office at school? _____Yes _____No

______________________________________        __________________________________________
Prescriber’s Signature                Date Signed

______________________________________        __________________________________________
Prescriber’s Name Printed                Prescriber’s Address

______________________________________        __________________________________________
Prescriber’s Emergency Phone Number                Prescriber’s Address

Parent Authorization

I authorize my son/daughter, to self-administer the above-referenced medication at school, school-sponsored activities, while under the supervision of school personnel, and before/after school care on school operated property. (I understand Kent ISD recommends I provide an additional dose of the medication to be kept at school in the event my child forgets or loses his/her medication.)

______________________________________        __________________________________________
Parent’s Signature                Date Signed
Kent ISD Secondary Campus
Authorization for Student Self- Medication Form

Student Authorization

I agree to:

- Demonstrate correct use of the inhaler or Epinephrine auto-injector using a trainer/demonstrator to the designated school personnel.
- Never share the inhaler of Epinephrine auto-injector with another person.
- Notify a teacher or other responsible adult if there is not marked improvement in my breathing within several minutes after two puffs of the inhaler.
- Immediately notify a teacher or another responsible adult if I use my Epinephrine auto-injector.

Student Signature: ___________________________ Date: ___________________________