Flint Community Schools
Health Services

3501 Minnesota Ave. 48506
Phone: 810-424-4087
Fax: 810-760-4705

ADMINISTRATION OF MEDICATIONS BY SCHOOL PERSONNEL
PARENT INFORMATION

Dear Parents/Legal Guardians:

Please return the attached Medication Consent Form to the school as soon as possible to enable us to aid you in the administration of your child's medication.

The first dose of a new medication should be given at home so the student can be observed for possible side effects or reactions.

We ask that you adhere to the following information as dictated by the state with recommendations from the district when sending medication of any kind to the school:

1. **Prescription medications will only be given with:**
   - ❖ Signed medication consent from parent/guardian
   - ❖ Authorization of the health care provider (current pharmacy prescription label)

   Please note, changes in prescription must be accompanied by a written prescription and a new-signed medication consent form.

2. **Medication must be in the most current original prescription bottle or box (i.e., inhaler) clearly labeled with:**
   - ❖ Student's name
   - ❖ Name of medication
   - ❖ Date
   - ❖ Dosage and time to be given (A.M. dose should be given at home)
   - ❖ Route of administration (i.e. by mouth)
   - ❖ An expiration date
   - ❖ Name and phone number of health-care provider

   Most pharmacies will provide you with duplicate containers if you request them.
   Staff shall not be responsible for cutting, breaking or dividing tablets, capsules or pills.

3. **Non-prescription medication will only be given with:**
   - ❖ Signed medication consent from parent/guardian
   - ❖ Written authorization by the health-care provider
   - ❖ Must be in the original container
   - ❖ Clearly labeled with student's name, dosage, and time to be given

4. Sufficient supply should be sent to school to insure enough medication to last for the prescribed length of time. Send a minimum of one week's supply.

5. Medication, including refills, must be brought to school by an adult for obvious safety reasons.

6. In order to keep medications in our schools at a minimum, we request that you administer medication ordered three times a day School Year_____
Student:_____School:_____
Date of Birth:_____Grade:_____Room:_____
or less at home, unless the health-care provider orders the medication to be given at a specific time during school hours as designated by school policy.

7. A health care provider's written authorization is needed for medication to be carried on the student during school hours. A staff person designated by the building administrator will instruct the student of responsibilities involved and inform personnel of medication being carried.

8. The building administrator may discontinue the student's self-administration privileges upon advance notification to the parent/guardian.

9. Discontinuation of medication requires a **written physician or parental statement.** Any leftover medication will be sent home via the parent.

10. All food utensils (i.e., measuring device, crusher, etc.) needed to administer medication is to be supplied by the parent/guardian and clearly labeled with the student's name.

11. All medication is to be picked up by parent/guardian at the end of the school year or it will be discarded.

12. A new Medication Consent Form and a supply of medications are needed **each** school year.

Please contact the school if you have any questions concerning medications policy and procedures.

Sincerely,

Flint Community Schools
Medication Consent Form

Physician:_____Physician Number:_____

Medication Name:_____Strength:_____Dosage:_____

Allergies:_____SideEffects:_____

Form of Medication/Treatment: Tablet/Capsule Liquid Inhaler Injection Nebulizer
Other

Instructions (schedule and dose to be given at school):_____

I, the undersigned parent or legal guardian, request that my child_____ receive the above medication at school according to the school district's medication policy. Furthermore, my request and permission for administration of medication constitute my agreement to indemnify, hold harmless, and release the district, its employees and agents from any and all claims and liability arising from the administration of medication requested above.

Parent/Legal Guardian: _____Date:_____
(Please Print) Address:
_____

Telephone (H): _____(W):_____Ext:_____
Cell/Pager:_____

**Please initial below those items that apply

_____I give permission to contact the prescribing health care provider and to exchange pertinent
(initial) medical information with the provider as well as appropriate school personnel.

_____I have reviewed the Flint Community Schools Medication Consent Information.
(initial)

_____I request that my child be allowed to carry and to self-administer the above medication at school
(initial) according to the school district's policy. I understand that a **Health Care Provider's statement is required**. This student is both capable and responsible for carrying and self-administering this medication.*

Signature:_____

*Physician's statement received:_____