MEDICATION PERMISSION FORM

I give permission for the Springville Community School District school nurse, or his/her authorized representative, to administer the below named medication to my child and agree to:

1. Submit this completed Medication Permission Form to the school.

2. Personally ensure that the medication is received by the school is in the original labeled container as dispensed by the prescribing health care provider, licensed pharmacist, or is in the manufacturer's container. Personally ensure that the container in which the prescription medication is dispensed is marked with the medication name, dosage and dosage interval.

3. Personally ensure that a responsible adult deliver the medication to the office. School Board Policy indicates that medication must be brought to school by the parent, guardian, or responsible adult only. Do not send medication with the student.

4. I understand that any medication to be given at school will be prescribed by a licensed legal prescriber in the state of Iowa. A licensed legal prescriber in the state of Iowa includes: MD, DO, PA, DNP, and ARNP. The only exceptions are for the over the counter medications which require parent or guardian permission through PowerSchool.

5. I understand that Springville Community School District will only administer medication that has approval from the FDA in accordance to the Iowa Department of Education and the Iowa Board of Nursing. Supplements, natural remedies, and essential oils will not be administered by the school nurse or her/his authorized representative.

_____ _____ _____
Parent/Guardian Signature Daytime Phone Date

INFORMATION OF MEDICATION TO BE ADMINISTERED:

Student: _____Date of Birth _____

Grade: _____TEACHER: _____

Medication: _____Strength_____

Dosage: _____End Date_____

Time: At Home: _____At School:_____

Medication prescribed by _____M.D, DO, PA, DNP or ARNP. Phone_____

_____

CONSENT FOR RELEASE OF INFORMATION:
I give permission for the parties named below to exchange written and verbal information with personnel at Springville Community School regarding the above-named student. If this medication is for attention or behavior concerns, Springville Community School may send behavior checklists to the health care provider named below. This permission is good for one school year.
Specific authorization for release of information protected by state or federal law:
My signature releases all information related to (check appropriate spot):

_____Mental Health/Psychological _____Substance Abuse _____Communicable Diseases

Physician Name: _____Phone_____

Parent/Guardian Signature _____

Daytime Phone_____ Date _____