SCOTTSDALE CHRISTIAN ADADEMY

MEDICATION POLICY AND PROCEDURE

CONSENT TO ADMINSTER PRESCRIPTION MEDICATION AND OVER-THE-COUNTER MEDICATION

It is strongly recommended that medication be administered at home if at all possible. **ALL MEDICATION must be kept in the Health Office and not with the student.** The school nurse and or designated staff will not be responsible or liable for any reaction to medications administered according to the directions in this request. If students must take medication at school, either by physician's order or parent's request, the following guidelines will apply:

Administration of Prescription Medication

- Medication must be delivered to the nurse in the prescription container as prepared by the pharmacist. The number of pills may be documented upon receipt by the school nurse.
- The prescription label must bear the student's name, current date, name of medication, dosage, time to be given, and name of prescribing practitioner.
- A copy of the practitioner's prescription order must be provided to the Health Office.
- The school nurse may consult with the provider regarding medication.

Administration of Non-Prescription Medications

- Medication must be delivered to the nurse in the original container as packaged by the manufacturer and labeled with the student's name.
- Dosage must be administered according to the manufacturer's recommendations as printed on label.

This form must be completed by the parent/guardian requesting/authorizing administration of medication and/or food supplements at school. To protect the student against theft or misuse of medication, medication should not be transported between home and school by the student. The parent/guardian will manage transport of medication if necessary. Medication remaining in the Health Office after the end of the school year will be discarded.

Please complete the following information and return the entire page to school nurse

Student's Name_____ DOB_____Grade/Teacher_____

Medication_____ Reason for Medication/Diagnosis_____

Dose_____Time and Date for Medication administration_____

I hereby authorize the school nurse or the school staff designee to administer the requested medication described above to my child whom I have named as the student.

Parent/Guardian Signature_____Date_____

Nurse Signature_____Date_____