Weatherford Independent School District

Health Services

GUIDELINES FOR ADMINISTRATION OF MEDICATION AT SCHOOL

All medications should be given at home if possible including the *first dose* of any medication. Administration time of medications should be adjusted so that only one dose will need to be administered at school. All medications must be given directly to the campus nurse and checked in to the clinic. The school nurse has discretion to use her professional judgment in medication administration.

1. All **prescription medication** must be:
   a. Provided by the parent/guardian and accompanied by a signed permission slip.
   b. In its original container, properly labeled.
   c. Inhalers must be kept in the nurse's office. A student may only carry an inhaler if a physician's order is provided to the school. In the event that a student must carry an inhaler, an additional inhaler should be kept in the nurse's office.
2. All **over the counter medication** must be:
   a. Provided by parent/guardian and accompanied by a signed permission slip.
   b. In its original, age-appropriate container and will only be administered according to label directions.
   c. Will not be given more than 10 consecutive days without a physician's order.
3. All **sample prescription medication** must be:
   a. Provided by parent/guardian and accompanied by a signed permission slip.
   b. In its original container, will only be administered with a physician's order.
4. All **alternative medicine** must be:
   a. Provided by parent/guardian and accompanied by a signed permission slip.
   b. In its original container, accompanied by a patient information sheet listing ingredients, actions, and side effects.
   c. Will only be given with a physician's order including dosage information.
5. The District cannot assume any responsibility for loss or negligent behavior when a student carries his/her medication without knowledge of the nurse.
6. Any medication not picked up by a parent/guardian at the **end of the year** will be discarded.

PARENTAL REQUEST FOR MEDICATION ADMINISTRATION DURING SCHOOL HOURS

In order for this student to remain in school, it is necessary that the following medication be given during school hours as directed.

STUDENT:_____

TEACHER/GRADE_____ DATE OF BIRTH_____

NAME OF MEDICATION_____DOSE_____TIME_____

NAME OF MEDICATION_____DOSE_____TIME_____

NAME OF MEDICATION_____DOSE_____TIME_____

I request that the medication specified above be administered to my child.

SIGNATURE OF PARENT/GUARDIAN_____

DATE_____