MFL MarMac Community School District
700 South Page Street • P.O. Box 1040 • Monona, Iowa 52159-0544

Jennelle Schroeder, RN District Nurse Phone: (563) 873-2250 Fax: (563) 873-2371

Permission for Medication During School Hours

Student's Name: _____ Grade: _____ Teacher/Advisor: _____

Date this form is in effect: _____ to _____ unless otherwise stated by parent.

May this information about your child's medication be shared with school personnel that are directly involved with his/her care?

YES _____ NO_____ Explanation: _____

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PRESCRIPTION MEDICATIONS

(to be completed and signed by healthcare provider AND signed by parent/guardian)

Name of Medication: _____

Form supplied (circle one) Tablet Capsule Liquid Ointment Drops * **Inhalers/Epinephrine delivery devices require a different form**

Dosage: _____ Time(s) to be given at school: _____

Student's Health Problem/Reason for Medication: _____

Prescribed by: _____ Hospital/Clinic: _____

Address: _____ Phone: _____ Fax: _____

Special Instructions: _____

Healthcare Provider Name: _____ Signature: _____ Date: _____

Parent/Guardian Signature: _____ Date: _____

NOTE: <u>ALL</u> prescription medications <u>MUST</u> be brought to school by an adult per school policy, not sent to school with the child and will be in locked storage in the nurse's office.

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OVER-THE-COUNTER OR NON-PRESCRIPTION MEDICATIONS

(to be completed and signed by parent/guardian)

Name of Medication: _____

Form supplied (circle one) Tablet Capsule Liquid Ointment Drops Other: _____

Dosage: _____ Time(s) to be given at school: _____

Student's Health Problem/Reason for Medication: _____

Special Instructions: _____

Parent/Guardian Signature: _____ Date: _____

NOTE: Non-Prescription Medications are not provided by the school, simply administered. They may be brought to school by a student, but <u>MUST</u> be kept in the nurse's office per school policy.