Jonesboro Public Schools

Medication Administration Release Form

Date: _____

To: **Jonesboro Kindergarten Center**

Address: 618 W. Nettleton
Jonesboro, AR 72401
Phone: 870-933-5835 Fax: 870-933-5834

I request that you give medication to my child during the school day in accordance with the Board Policy below. You are authorized to delegate this authority to another person if so desired. I will not hold the school staff responsible for any undesired reaction, which may occur from the medication.

I agree to pay for ambulance service if used to transport my child from school to the doctor or hospital should he/she have a reaction to the medication.

Parent Signature_____

Student Name_____Grade_____

Name of Medication_____ Dosage_____

Time(s) to be given _____for treatment of the following illness_____

In case of emergency call_____ Phone_____

Hospital to be called_____ Phone_____

Doctor to be called_____ Phone_____

Medication Policy Guidelines

1. The medication must be in the original container with the child's name on the prescription.
2. No medication to be given 3 times daily or less will be administered at school.
3. No over-the-counter drugs will be given at school, as school personnel are not trained to determine when medications are needed and this is a form of prescribing.
4. **PARENT** and **PHYSICIAN** must sign the consent form before any medication will be given at school. **HANDWRITTEN NOTES ARE NOT ACCEPTABLE.**
5. Permission for long-term medication must be renewed at the beginning of each Semester.

Physicians Order

It is necessary for my patient _____, to receive the following medication at school.

Medication: _____ Dosage: _____ Time(s) to be given: _____

_____ _____
Physicians Signature Date