Jonesboro Public Schools
Medication Administration Release Form

Date: _____ School Name:_____
School Address:_____.
Jonesboro, AR 72401
Phone:870-_____
Fax:870-_____

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.) Prescription medication must be in the original container with: the child's name, ordering health care provider's name, dosage, frequency, and instructions for administration.
2.). All medications will be given according to labeling directions on the container. Deviations from label directions will require a written providers order.
4.) 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
5. A provider order and consent form signed by parent must be on file for all medications given at school. **HANDWRITTEN NOTES ARE NOT ACCEPTABLE.**

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