Jonesboro Public Schools
2506 Southwest Square
Jonesboro, AR
72401

Date: _____To:_____

I request that you give medication to my child during the school day in accordance with the Board policy printed 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 that may occur from the medication. I also 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's Signature: _____

Student's Name: _____

Medication: _____Dosage:_____

Time to be given: _____for the treatment of_____

In case of an 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 over-the-counter medications will be given at school, as school personnel are not trained to determine when medications are needed and this is a form of prescribing. (Unless ordered by a physician as stated below).

3. A PARENT and PHYSICIAN must sign the consent form, before any medication will be given at school. HANDWRITTEN NOTES ARE *NOT* ACCEPTABLE.

4. Permission for long-term medication must be renewed at the beginning of each school year.

PHYSICIAN'S ORDERS

It is necessary for my patient, _____ to receive the following

Prescription medication: _____Dosage:_____ __Time:_____

Physician's Signature: _____

Physician's Name Printed: _____ Date: _____