



**When it is necessary for a student to take medication during school hours, the following requirements must be met:**

1. Prescription medication must be in the **original** container with a non-expired prescription label that matches the written physician's order.
2. Over-the-counter medications must be in the **original** container with original package directions.
3. Age appropriate dosage as stated on the label will only be dispensed.
4. In order for ALP to administer medications to a student, a Medication Permission Consent Form must be signed by the parent/guardian and physician. Dosage, time, routes and dates to be given, and the name of the medication must be clearly stated.
5. All medication must be dropped off and picked up at school by an **adult** only.
6. All inhalers, self-carry or not, must have a pharmacy placed label on it or have the inhaler inside of the box with the pharmacy label. Inhalers not properly labeled are not allowed per district policy. Parents must complete the Consent to Carry Inhaler form and return it to the ALP office prior to the student carrying an inhaler on campus.
7. Medications prescribed to be given three times per day, **will not** be given at school unless the prescribing physician states in writing that the medication, such as ADHD medication must be administered during school hours. Please make arrangements to give medications before or after school.
8. Narcotic pain medication will not be given at school, even with a physician's order.
9. Essential oils will not be applied or used at school. Essential oil diffusion is not permitted in the classrooms.
10. Supplements and vitamins will not be given at school unless we are provided with a physician's order.
11. No forms of cannabis will be administered to students for medicinal purposes, even with a physician's order.
12. Medications brought to school and not meeting the necessary requirements will not be dispensed. The medication will be locked in the office until a parent/guardian verifies the medication, signs the proper forms or takes it home.
13. Please contact the ALP office regarding further information on inhaler and epi-pen order for any student.



**Consent for Administering Medication at School**

Short Term Prescription     Inhaler (not self-carrying)     Over the Counter Medication

Student Name: \_\_\_\_\_ Grade: \_\_\_\_\_ DOB: \_\_\_\_/\_\_\_\_/\_\_\_\_

Student ID: \_\_\_\_\_ Homeroom Teacher: \_\_\_\_\_

Medication: \_\_\_\_\_

Reason for Medication: \_\_\_\_\_

Dosage: \_\_\_\_\_

Time of Day to be Administered: \_\_\_\_\_

Physician Name: \_\_\_\_\_

Physician Phone: \_\_\_\_\_ Physician Fax: \_\_\_\_\_

**Parent/Guardian Consent**

I DO  I DO NOT  specifically consent to the transmission of my child's medical records via fax.

I give consent to the school designated personnel to administer the above listed medication. I understand that all medication must be hand delivered by an adult to the school and in its original container.

Note: A physician's permission is required for medication to be administered for an extended period or quantity other than listed on the label.

Parent/Guardian Signature \_\_\_\_\_

Date: \_\_\_\_\_ Phone number: \_\_\_\_\_



**Request for School Administration of Prescription Medication**

For children to receive medication while at school, both sections A and B of this form need to be completed prior to its administration.

School Year \_\_\_\_\_ / \_\_\_\_\_

**A. Parent/Guardian request to administer medication at school.**

I request that ALP designated staff member give my child, \_\_\_\_\_,  
the medication as prescribed by our health care provider, \_\_\_\_\_.

The medication is to be furnished by me and is to be in the original container from the pharmacy with the label matching the written doctor's order. If any changes in medication or dosage occur, the school must be notified immediately, and a new form must be completed. Student misuse of medication being self-administered will result in confiscation and disciplinary action.

I DO  I DO NOT  specifically consent to the transmission of my child's medical records via fax.

Parent/Guardian Signature: \_\_\_\_\_ Date: \_\_\_\_\_

Phone Number: \_\_\_\_\_ Email: \_\_\_\_\_

**B. Health Care Provider's Order for Medication at School** (Must be completed by a health care provider)

I request the following student be given medication at school because I believe there exists a valid health reason which makes the administration of medication advisable during the time the child is under the supervision of the school.

Student Name: \_\_\_\_\_ DOB: \_\_\_\_\_

Condition being Treated: \_\_\_\_\_

Medication to be Administered: \_\_\_\_\_

Dosage, Mode, and Time to be Given: \_\_\_\_\_

Side effects to be expected: \_\_\_\_\_

Other Medications being taken: \_\_\_\_\_

Health Care Provider's Name (please print): \_\_\_\_\_

Health Care Provider's Signature: \_\_\_\_\_

Phone Number: \_\_\_\_\_ Fax Number: \_\_\_\_\_



**Authorization for Students to Self-Carry Emergency Medication**

A new form must be completed each school year. Forms are kept in the Main Office.

School Year \_\_\_\_\_ - \_\_\_\_\_

Student Name: \_\_\_\_\_ DOB: \_\_\_\_/\_\_\_\_/\_\_\_\_ Grade: \_\_\_\_\_

The medication identified on this form must be brought in in the original container appropriately labeled by a pharmacist with the student's name. The directions must duplicate the directions given on this request.

This area must be completed by a Parent or Guardian

Name of Medication to be Given: \_\_\_\_\_

Purpose of the Medication: \_\_\_\_\_

Frequency of Use: \_\_\_\_\_ Prescribed dosage at School: \_\_\_\_\_

Side effect of medication, if any: \_\_\_\_\_

Other medications student is receiving: \_\_\_\_\_

Inhaler YES \_\_\_\_\_ NO \_\_\_\_\_

Diabetes supplies/medication (be specific): \_\_\_\_\_

\*Epinephrine Injector YES \_\_\_\_\_ NO \_\_\_\_\_

\*Glucagon YES \_\_\_\_\_ NO \_\_\_\_\_

\*911 will be called if Epinephrine or Glucagon has been used.

*I understand the above-named student is responsible for keeping the medication and/or equipment and supplies safely on his/her person. An extra supply of this medication should be kept in the ALP Main Office for emergency use. The student should report to the office in the event of an emergency, if possible. ALP is not responsible for the loss of medication. The student is expected to adhere to ALP's policy regarding medications.*

Parent/Guardian name (please print): \_\_\_\_\_

Parent/Guardian Signature: \_\_\_\_\_ Date: \_\_\_\_\_