

MEDICATION AGREEMENT



Building Bright Futures

Department of Health Services

Student Name: _____ Student Number: _____

School: _____ Grade/Teacher: _____

TO BE COMPLETED BY PARENT OR GUARDIAN

I hereby request and give my permission to the Jefferson County School District to administer medication to my child. I understand that it is my responsibility to provide the medication in the original pharmacy/or physician labeled container that has the correct medication dosage identified for my student. I also understand the school may not alter or change any medications from their original form (cut or half pills, etc.)

Any prescription changes will require an additional signed and completed Medication Agreement.

Name of Student: _____ Date of Birth: _____

Medicaid? No Yes Medicaid Number: _____

Parent/Guardian Name: _____ Home/Work Phone: _____

Name of Medication: _____ Dosage: _____ Time: _____

Start Date: _____ End Date: _____ Route: _____

I give my permission for the school staff to contact the prescribing physician regarding this medication.

Signature of Parent/Guardian Date

TO BE COMPLETED BY PHYSICIAN (FOR PRESCRIPTION)

Patient's Name: _____ Date of Birth: _____

Medication: _____ Purpose: _____

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

Start Date: _____ End Date: _____ Route: _____

Name of Physician: _____ Office Phone Number: _____ Fax _____

Signature of Physician Date

Only school employees who are trained and delegated by the District Registered Nurse Consultant may administer medication. The employee administering the medication must document the time they gave the medication in the appropriate box and then initial in the appropriate box.

Name of District Registered Nurse Consultant who trained and delegated: _____

Initials	Person Dispensing Medication	Title	Date Delegated
_____	_____	_____	_____
_____	_____	_____	_____
_____	_____	_____	_____

SUPPLEMENTAL MEDICATION LOG

Attach to the completed Medication Agreement (Form #924) for this medication.

Student Name: _____
 Student Number: _____
 Date of Birth: _____

Medication: _____
 Dose #1 Start time: _____
 Dose #2 Start time: _____

Month:		Year:			
Week 1	Mon	Tue	Wed	Thu	Fri
Date					
#1 Time					
Initials					
#2 Time					
Initials					

Month:		Year:			
Week 1	Mon	Tue	Wed	Thu	Fri
Date					
#1 Time					
Initials					
#2 Time					
Initials					

Month:		Year:			
Week 1	Mon	Tue	Wed	Thu	Fri
Date					
#1 Time					
Initials					
#2 Time					
Initials					

Month:		Year:			
Week 2	Mon	Tue	Wed	Thu	Fri
Date					
#1 Time					
Initials					
#2 Time					
Initials					

Month:		Year:			
Week 2	Mon	Tue	Wed	Thu	Fri
Date					
#1 Time					
Initials					
#2 Time					
Initials					

Month:		Year:			
Week 2	Mon	Tue	Wed	Thu	Fri
Date					
#1 Time					
Initials					
#2 Time					
Initials					

Month:		Year:			
Week 3	Mon	Tue	Wed	Thu	Fri
Date					
#1 Time					
Initials					
#2 Time					
Initials					

Month:		Year:			
Week 3	Mon	Tue	Wed	Thu	Fri
Date					
#1 Time					
Initials					
#2 Time					
Initials					

Month:		Year:			
Week 3	Mon	Tue	Wed	Thu	Fri
Date					
#1 Time					
Initials					
#2 Time					
Initials					

Month:		Year:			
Week 4	Mon	Tue	Wed	Thu	Fri
Date					
#1 Time					
Initials					
#2 Time					
Initials					

Month:		Year:			
Week 4	Mon	Tue	Wed	Thu	Fri
Date					
#1 Time					
Initials					
#2 Time					
Initials					

Month:		Year:			
Week 4	Mon	Tue	Wed	Thu	Fri
Date					
#1 Time					
Initials					
#2 Time					
Initials					

Month:		Year:			
Week 5	Mon	Tue	Wed	Thu	Fri
Date					
#1 Time					
Initials					
#2 Time					
Initials					

Month:		Year:			
Week 5	Mon	Tue	Wed	Thu	Fri
Date					
#1 Time					
Initials					
#2 Time					
Initials					

Month:		Year:			
Week 5	Mon	Tue	Wed	Thu	Fri
Date					
#1 Time					
Initials					
#2 Time					
Initials					

Signature _____
 RN: _____ Date: _____

Signature _____
 RN: _____ Date: _____

Signature _____
 RN: _____ Date: _____

AB= absent **FT**=field trip **NS**=no show **SO**=school is out **SR**=student refused