PRESCRIPTION MEDICATION PERMIT 2023-2024
WELLINGTON-NAPOLEON R-IX SCHOOLS HEALTH SERVICES

STUDENT_____GRADE_____TEACHER_____DOB_____

Allergies_____

Dispensing Phrmacy_____ _____RX#_____RX#_____RX#_____

Prescribing physician_____Physician's Phone_____Length of time to take medication_____

Name of Prescribed Medication_____Dosage_____Route_____Time_____For TX of_____

I hereby give my permission for the above medication to be given at school. The Nurse or designated substitute may give this medication.

All medication must be brought to the school in the current prescription bottle by a parent/guardian.

Date_____Parent/Guardian_____ Date_____Nurse_____

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STUDENT_____GRADE_____TEACHER_____DOB_____

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I hereby give my permission for the above medication to be given at school. The Nurse or designated substitute may give this medication.

All medication must be brought to the school in the current prescription bottle by a parent/guardian.

Date_____Parent/Guardian_____ Date_____Nurse_____

NON-PRESCRIPTION MEDICATION PERMIT 2023-2024

WELLINGTON-NAPOLEON R-IX SCHOOLS, HEALTH SERVICES

STUDENT_____GRADE_____TEACHER_____DOB_____

Allergies_____ Length of time to take medication _____

Name of Medication_____Dosage_____Route_____Time_____For TX of_____

I hereby give my permission for the above medication to be given at school. The Nurse or designated substitute may give this medication.

All medication must be brought to the school in the bottle by a parent/guardian.

Date_____Parent/Guardian_____ Date_____Nurse_____

NON-PRESCRIPTION MEDICATION PERMIT 2023-2024

WELLINGTON-NAPOLEON R-IX SCHOOLS, HEALTH SERVICES

STUDENT_____GRADE_____TEACHER_____DOB_____

Allergies_____ Length of time to take medication _____

Name of Medication_____Dosage_____Route_____Time_____For TX of_____

I hereby give my permission for the above medication to be given at school. The Nurse or designated substitute may give this medication.

All medication must be brought to the school in the bottle by a parent/guardian.

Date_____Parent/Guardian_____ Date_____Nurse_____

Permission for Student to Carry and Self-Administer Prescribed Asthma Medication

Student Name:_____ Grade/Teacher:_____

Medication(s) to self-carry:_____

According to Missouri Law, students may be allowed to carry and self-administer prescribed medication while at school, at a school-sponsored activity and in transit to or from school or school-sponsored activity when they meet the following requirements:

- A physician prescribed the medication for use by the student and instructed the student in the correct and responsible usage of the medication.
- The student has demonstrated to the student's licensed physician or the licensed physician's designee, and the school nurse the skill level necessary to use the medication and any device necessary to administer such medication prescribed or ordered.
- The student's physician has approved and signed a written treatment plan for managing the student's chronic health condition, including asthma or anaphylaxis episodes and for medication for use by the student. Such plan shall include a statement that the student is capable of self-administering the medication under the treatment plan. The plan may be effective only for the same school year it is granted and must be renewed each year.
- The student's parent/guardian has completed and submitted to the school any written documentation required by the school, including the treatment plan and a liability statement acknowledging the school district and its employees shall incur no liability as a result of any injury arising from the self-administration of medication by the student.

PHYSICIAN STATEMENT FOR STUDENT TO SELF-ADMINISTER QUICK-RELIEF MEDICATION:

I certify that the above named student has a medical history of asthma, has been instructed in the proper self-administration of the medications(s) listed above and is judged to be capable of carrying and self-administering the medication(s). The student has been instructed to notify the school nurse if one dose of medication fails to relieve asthma symptoms within 20 minutes or fails to sustain the student for at least 3 hours. This student understands the hazards of sharing medications with others and has agreed to refrain from the practice. I have provided an Asthma Plan for the student to follow and provide a copy to the school.

Physician Signature:_____ Date:_____

PARENT/GUARDIAN STATEMENT FOR STUDENT TO SELF-ADMINISTER MEDICATION:

I, the parent/guardian of the above named student, give permission for this student to carry and self-administer the above listed medication(s). I have reinforced that my student should notify the school nurse if one dose of medication fails to relieve asthma symptoms within 20 minutes or fails to sustain my student for at least 3 hours. I acknowledge that the school district and its employees shall incur no liability as a result of any injury arising from the self-administration of the medication by my student.

Parent/Guardian Signature:_____ Date:_____

Responsibilities for carrying Inhalers: (to be checked by the School Nurse)

☐Yes ☐No Student is able to identify signs and symptoms of asthma & need for asthma medication(s)

☐Yes ☐No Student agrees to come directly to Health Room as needed (med doesn't help within 20 mins or last 3 hours)

☐Yes ☐No Student demonstrates proper inhaler technique to ensure good delivery of medication

☐Yes ☐No Student has another inhaler in Health Room for back up (recommended, not required)

☐Yes ☐No Student knows that medication carried must have prescription label attached, to identify the medication's owner

School Nurse Signature:_____ Date:_____

Permission for Student to Carry and Self-Administer Prescribed Epinephrine

Student Name:_____ Grade/Teacher:_____

Medication(s) to self-carry:_____

According to Missouri Law, students may be allowed to carry and self-administer prescribed medication while at school, at a school-sponsored activity and in transit to or from school or school-sponsored activity when they meet the following requirements:

- A physician prescribed the medication for use by the student and instructed the student in the correct and responsible usage of the medication.
- The student has demonstrated to the student's licensed physician or the licensed physician's designee, and the school nurse the skill level necessary to use the medication and any device necessary to administer such medication prescribed or ordered.
- The student's physician has approved and signed a written treatment plan for managing the student's chronic health condition, including asthma or anaphylaxis episodes and for medication for use by the student. Such plan shall include a statement that the student is capable of self-administering the medication under the treatment plan. The plan may be effective only for the same school year it is granted and must be renewed each year.
- The student's parent/guardian has completed and submitted to the school any written documentation required by the school, including the treatment plan and a liability statement acknowledging the school district and its employees shall incur no liability as a result of any injury arising from the self-administration of medication by the student.

PHYSICIAN STATEMENT FOR STUDENT TO SELF-ADMINISTER EPINEPHRINE:

I certify that the above named student has a medical history of potentially life-threatening allergies, has been instructed in the proper self-administration of the medications(s) listed above and is judged to be capable of carrying and self-administering the medication(s). The student has been instructed to notify or have someone notify the school nurse if any signs or symptoms of an allergic reaction occur. This student understands the hazards of sharing medications with others and has agreed to refrain from the practice. I have provided a Food Allergy Action Plan for the student to follow and provide a copy to the school.

Physician Signature:_____ Date:_____

PARENT/GUARDIAN STATEMENT FOR STUDENT TO SELF-ADMINISTER MEDICATION:

I, the parent/guardian of the above named student, give permission for this student to carry and self-administer the above listed medication(s). I have reinforced that my student should notify the school nurse if any sign or symptoms of an allergic reaction occur. I acknowledge that the school district and its employees shall incur no liability as a result of any injury arising from the self-administration of the medication by my student.

Parent/Guardian Signature:_____ Date:_____

Responsibilities for carrying Inhalers: (to be checked by the School Nurse)

☐Yes ☐No Student is able to identify signs and symptoms of an allergic response & need for epinephrine administration

☐Yes ☐No Student agrees to come directly to Health Room following an allergic response

☐Yes ☐No Student demonstrates proper self-administration technique to ensure good delivery of epinephrine

☐Yes ☐No Student has another epinephrine auto-injector in Health Room for back up (recommended, not required)

☐Yes ☐No Student knows that medication carried must have prescription label attached, to identify medication's owner

School Nurse Signature:_____ Date:_____