JHCDE-2 - REQUEST FORM TO ADMINISTER MEDICINE

Highmore-Harrold School District

High School

Name of Student:_____ Birth date:_____

Address:_____ Phone:_____

Parent/Guardian:_____

Medicaid eligible?_____ If yes, Medicaid number:_____

WE ENCOURAGE MEDICATION HOURS BE ARRANGED OUTSIDE OF SCHOOL HOURS IF POSSIBLE. MEDICATION MUST BE IN ORIGINAL CONTAINER. PARENT OR RESPONSIBLE DESIGNATED ADULT MUST DELIVER THE MEDICATION TO SCHOOL. ALL MEDICATION WILL BE STORED IN THE OFFICE IN A LOCKED CONTAINER, INCLUDING OVER THE COUNTER MEDICATION.

Diagnosis:_____

Name of medication/treatment:_____

Total Daily Dosage:_____

Amount & Times to be administered at school:_____

Method of administration:_____

Duration {week, month, year}:_____

Precautions and reactions to observe and report:_____

_____

Physician's Signature:_____

Physician's phone number:_____

Parent's Statement: (circle one)

Option I: I request and authorize personnel at the Highmore-Harrold School to supervise the medication/treatment prescribed on this form to my child. I understand the medication must be provided in a bottle, identifying the name and telephone number of the pharmacy, the student's name, physician's name and dosage of the drug to be taken. I understand that the school district and individuals involved will not be held liable for any adverse effects of the medication. In addition, I understand that I am responsible to deliver the medication to the school and to pick up unused

medication on or before the last day of school or one week after the last dose is given. If the medication is not picked up, it will be destroyed.

Option II: I authorize my child to take his/her own medication while at school and relieve the school district and personnel of the responsibility of dispensing the medication. This option is used when the child can identify the medication, knows the frequency and time of day for which medication should be taken. School personnel will follow the district procedure for documentation of medication.

_____ _____

Parent's Signature Date

Highmore-Harrold School District
Highmore, South Dakota

(Release of Responsibility-High School Students Only)
Option II

I authorize my child to take his/her own medication while at school and relieve the school district and personnel of all responsibility.

_____ _____

Parent's Signature Date

Name of Student:_____

Medication:_____

High school students have the option of carrying 1 (one) dose for the day of their needed medication. Medications <u>will not</u> be allowed in student lockers, desks, or book bags. Medications <u>must be on</u> the student.