MEAD PUBLIC SCHOOLS
ADMINISTRATION OF MEDICATION RELEASE FORM

Student Name: _____ Grade: _____

Name of Medication as on original container:_____

Medication Dates: Begin: _____ End: _____ Dosage/Time to Administer:_____

FOR BOTH PRESCRIPTION AND NON PRESCRIPTION MEDICATIONS
(Separate Form Required for Asthma, Anaphylaxis or Diabetes Medications)

CHECK ONE (1) OF THE FOLLOWING BOXES

_____I hereby authorize any of the employees of the Mead Public Schools to allow the Student to self administer the above-described medication without monitoring or supervision by school personnel. While the student may be allowed to self administer the medication, the medication must still be turned in to the office and will be maintained in the office. If the medication is a Prescription, the medication labeling or a statement from the physician indicating that self administration is permitted must be included with the medication. The student agrees to follow the dosage directions on the medication and further agrees not to share or dispense said medication to others.

_____I hereby request any of the employees of the Mead Public Schools to administer the above-named medication to the Student, in accordance with the prescribing physician's instructions for Prescription Medications and/or in accordance with the packaging directions on Non-Prescription Medications. Further, I agree to:

1. Submit this request to the principal or school secretary.
2. IF the medication is PRESCRIPTION, make certain the following conditions have been met:
   - Medication must be received in the container in which it was dispensed by the prescribing physician or licensed pharmacist
   - Medication must be marked with the medication name, dosage, interval dosage
   - Unless indicated otherwise in writing by the physician, the medication will not be administered after the date for which it would have been completely taken in accordance with the directions on the prescription
   - Prescriptions not filled within the last thirty (30) days must be accompanied with a note from the physician or revised labeling from the pharmacy authorizing administration of the medication
   - Any possible adverse side effects and/or special instructions must be included with the medication in the information included from the physician or pharmacist or by noting such on this form
3. Make certain that any Non-Prescription Medication provided is in its original container and contains clear directions for its administration and is marked with the Student's Name.
4. Submit a revised statement from the physician to the principal or school secretary if any of the information regarding the medication changes.
5. Provide directions to school personnel providing either Prescription Medication or Non-Prescription Medication. Such directions may clarify but must not contradict any of the information provided with the medication.
6. Provide monitoring of the medication's effects, and assume full responsibility thereof.
7. List any possible Possible adverse reactions to be reported to the physician:

   _____

8. Provide special instructions for provision and storage of the medication:

   _____

The undersigned hereby authorizes the Mead School District and its employees to administer medication to the above named student in accordance with the provisions contained in this document. The undersigned student, if self administering a medication, agrees to follow the dosage directions on the medication and to not allow other students to handle or take the medication.

_____ _____ _____
Caretaker (Parent) Signature Student Signature(if self administering) Date

_____ _____
Home Telephone Number Alternative Numbers