General Medication Packet

- Schedule an appointment with your child's health care provider over the summer to update medications and/or obtain new prescriptions (if needed).

- Parent: Complete and sign the Medical Release Form.

- Parent: Read and sign the Medication Authorization Form. A separate form is required for each medication

- Parent: Bring completed forms to the Clinic along with the medication. Students **cannot** bring the medication into school.

- Prescription medication must be in the original pharmacy bottle with a label attached.

- Over-the-counter medication must be in an unopened bottle.

HEALTHCARE SERVICES LETTER

Dear _____
Physician

_____

_____

Phone #: _____ Fax #: _____

In order to provide health services for: _____, DOB: _____
it is necessary to obtain a medical history, immunization history, and a health plan including a list of current medications administered at home/school.

Please forward all documentation to:

Attn: Danielle Calapa, RN

School: OCPS – Dommerich Elementary

_____

Address: 601 N. Thistle Lane
Maitland, FL 32751

Phone: 407-623-1407 Fax: 407-623-5738

RECORD RELEASE

I hereby give my permission to have any records of my child (health care plans, nursing care plans, immunization history, medical history, and medications) released to my child's school to aid school personnel in serving him/her.

I give my permission for designated school personnel to contact my child's physician regarding current/pending health issues.

_____ _____
Parent/Guardian Date

_____ _____ _____
Home Phone Number Work Phone Cell Number

Teacher:_____ Grade:_____

Authorization for Medications

Prescriptions and Non-Prescriptions

My permission is hereby granted to Dommerich Elementary School

To assist_____ DOB ___/___/_____
Last First Middle MM/DD/YYYY

NOTE: If the medication is a prescription, ask you pharmacist to prepare two containers, one for school and one for home. **THE VERY FIRST DOSE OF THIS MEDICATION FOR CURRENT CONDITION/ MAY NOT BE GIVEN AT SCHOOL.** Herbal, vitamin and aspirin (salicylic acid) products require a physician's order.

Name of prescription medication (ex. Ritalin, 20 mg.): _____

Name of prescribing physician: _____

Amount to be given/dosage (ex. 10 mg.): _____

Directions for administering (ex. by mouth): _____

Specific Time to be given at school: _____

Authorization: Beginning Date: _____ Ending Date: _____

Reason or health problem: _____

Possible reaction to medication: _____

OVER-THE-COUNTER MEDICATIONS NEEDED LONGER THAN ONE WEEK MUST HAVE REVIEW AND APPROVAL OF THE SCHOOL NURSE AND MAY REQUIRE A PHYSICIAN'S ORDER. OVER-THE-COUNTER MEDICATIONS NEED TO BE DOSAGE SPECIFIC FOR AGE/WEIGHT. Non-prescription medications will only be accepted in the factory sealed original container. It is hereby understood by the undersigned that school personnel are not held liable for the administration of the above medication or for its possible side effects.

Medication is to be brought in its current labeled pharmacy container. For safety and security reasons, medication must be transported to and from school by the parent/guardian. **DO NOT SEND MEDICATIONS TO SCHOOL WITH THE CHILD/SIBLINGS.** Notes from home will not be accepted as authorization for dispensing medication.

_____ _____/_____/_____
Signature of parent/guardian Date

(___)_____ (___)_____ (___)_____
Home phone Work phone Cell phone / Beeper

Remember to advise the school immediately of changes in the phone numbers, addresses, responsible emergency contact person, doctor, and hospital preference.

Medication Receipt/Pick-up Record

School Year_____

udent Name: _____ School: _____

	Date	Medication/Dose Received	Parent to be Given	Parent	OCPS Staff Initials	Parent/Guardian Signature
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2.						
3.						
4.						

	Date	Medication/Dose Picked Up	Amount picked up	OCPS Staff Initials	Parent/Guardian Signature
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