BURLINGTON COMMUNITY SCHOOL DISTRICT
MEDICATION PERMISSION FORM

Dear Parent/Guardian/Custodian:

The Board of Directors policy for the Burlington Community School District states, "Prescription medication will be administered only with written authorization of the parent and prescriber for the current school year." A current medical diagnosis with ICD 10 code and provider signature must be provided.

"Non-prescription medication will be administered only with written authorization that is signed and dated by the parent for the current school year."

All containers must be properly labeled and include the following information: name of medication, dosage, time to be given, name of doctor (if prescription medication), name of student, and route of administration. Both prescription and non-prescription medications must be in their original containers stating either the prescriber's instructions or manufacturer's directions.

The time of medication administration may need to be altered slightly to fit your child's schedule. Please remind your child that she/he is responsible to go to the school clinic at the appropriate time.

- I understand that the medication must be delivered to the school office in its original container.
- I understand that if the medication is a nonprescription medication (over-the-counter), there must be a parental/guardian/custodial authorization giving the student's name, the name of the medication, the dates, times, route of administration, and the dosage.
- I understand that if the medication is a prescription medication, the pharmacy label must show the student's name, the date prescribed, the name of the medication, the dosage, times and methods for administration, the expiration date, the prescribing physician, the name and address of the pharmacy, any special storage or administration procedures, and a description of any anticipated reactions.
- I understand I must submit a revised permission form signed by the physician if any of the information changes.
- I understand this request and authorization must be renewed each school year.
- I agree to cooperate with school personnel and the prescriber of the medications if questions arise.
- I agree to timely provide safe delivery of medication to and from school and to timely pickup remaining medications.

In order for your child to receive medication, please complete and sign this form.

PLEASE COMPLETE INFORMATION ON THE REVERSE SIDE OF THIS SHEET AND RETURN TO THE SCHOOL NURSE.

Reviewed: ~~07/18/16~~
11/15/21

Burlington Community School District Medication Permission Form

I am the parent/guardian/custodian of:

Student's Name: _____

Grade: _____ School: _____ Date of Birth: _____

I request and authorize school personnel to administer the following medication to my child:

Name of Medication: _____

Dosage: _____Time/Frequency: _____

Route of administration: _____

Start date: _____ End date:_____

Reason medication is being given: _____

_____

Special Directions and Signs or Side Effects to Observe: _____

_____

_____

The school district has my permission to contact the prescribing medical provider as needed regarding my child's health needs.

_____ _____
(Parent's signature) (Date)

_____
(Address)

_____
(Phone Number) (E-Mail Address)

Medical Provider's Information

Student's Diagnosis and ICD 10 codes: _____

_____

_____

_____ _____
(Provider Name – Please Print) (Provider Signature)

_____
(Clinic Name & Address) (Phone Number)

If you have questions, please contact the school nurse at your child's building.

Reviewed: ~~07/18/16~~
11/15/21