

TECUMSEH LOCAL SCHOOL DISTRICT

REQUEST AND PERMISSION FOR DISPENSING ANY MEDICATION AT SCHOOL

Since medication for the student listed below cannot be scheduled for other than school hours and the administration of such medication may be supervised by medically untrained personnel, it is necessary that all information be completed before medication can be administered by school personnel.

Both the parent or guardian and physician must complete and sign this form.

Physician's Request for the Administration of Medication

_____ is under my care and should receive _____
(name of student)

_____ at _____
(drug, dose, and route) (time to be given)

Date to begin _____ Date to end _____

Specific instructions _____

For students with diabetes only:

_____ I authorize the student to attend to his/her diabetes care and management, in accordance with my order, during regular school hours and school sponsored activities. I have determined that the student is capable of performing diabetes care tasks.

_____ I do not authorize the student to attend to his/her diabetes care and management during regular school hours and school sponsored activities.

Date _____ Physician Signature _____

Telephone _____ Address _____

Parent's Request for the Administration of Medication at School

A. I am requesting permission for my child named above to: (check all that apply)

_____ Use or receive prescribed medication or treatment

_____ for student with diabetes only: self-administer diabetes care in accordance with Policy 5336

B. I will assume responsibility for safe delivery of the medication/drug to school, except for the diabetes medication student is permitted to possess pursuant to Policy 5336.

C. I will notify the school immediately if there is any change in the use of the medication/drug or the prescribed treatment, or if I wish to revoke this authorization.

D. I release and agree to hold the Board of Education, its officials, and its employees harmless from any and all liability for damages or injury resulting directly from this authorization.

Signature of Parent/Guardian _____

Relationship to Child _____ Date of Request _____

Address _____ City _____

Home phone _____ Work phone _____

5/09

7/13

5/27/14

10/28/14

Medication Record 2015-2016

Name _____ Room/Teacher _____ Dosage _____ Time _____
 Date _____ Medication _____ Dosage _____ Time _____
 Date _____ Medication _____ Dosage _____ Time _____
 Date _____ Medication _____ Dosage _____ Time _____

Aug	1	2	3	4	5	6	7	8	9	10	11	12	13	14	15	16	17	18	19	20	21	22	23	24	25	26	27	28	29	30	31
	X	X	X	X	X	X	X	X	X	X	X	X	X	X	X	X	X	X	X	X	X	X	X	X	X	X	X	X	X	X	X

Sep	1	2	3	4	5	6	7	8	9	10	11	12	13	14	15	16	17	18	19	20	21	22	23	24	25	26	27	28	29	30	31
					X	X	H					X	X					I	X	K					X	X				X	

Oct	1	2	3	4	5	6	7	8	9	10	11	12	13	14	15	16	17	18	19	20	21	22	23	24	25	26	27	28	29	30	31
			X	X						X	X						X	X					I	X		X				X	

Nov	1	2	3	4	5	6	7	8	9	10	11	12	13	14	15	16	17	18	19	20	21	22	23	24	25	26	27	28	29	30	31
	X						X	X				X	X	X	X	X	X	X	X	X	X	X	X	X	X	X	X	X	X	X	

Dec	1	2	3	4	5	6	7	8	9	10	11	12	13	14	15	16	17	18	19	20	21	22	23	24	25	26	27	28	29	30	31
					X	X					X	X	X	X	X	X	X	X	X	X	X	X	X	X	X	X	X	X	X	X	

Jan	1	2	3	4	5	6	7	8	9	10	11	12	13	14	15	16	17	18	19	20	21	22	23	24	25	26	27	28	29	30	31
	H	X	X					X	X	X					X	X	X	X	X	X	X	X	X	X	X	X	X	X	X	X	

Feb	1	2	3	4	5	6	7	8	9	10	11	12	13	14	15	16	17	18	19	20	21	22	23	24	25	26	27	28	29	30	31
					X	X					X	X	X	X	X	X	X	X	X	X	X	X	X	X	X	X	X	X	X	X	

Mar	1	2	3	4	5	6	7	8	9	10	11	12	13	14	15	16	17	18	19	20	21	22	23	24	25	26	27	28	29	30	31
					X	X					X	X	X	X	X	X	X	X	X	X	X	X	X	X	X	X	X	X	X	X	

Apr	1	2	3	4	5	6	7	8	9	10	11	12	13	14	15	16	17	18	19	20	21	22	23	24	25	26	27	28	29	30	31
	X	X	X					X	X	X					X	X	X	X	X	X	X	X	X	X	X	X	X	X	X	X	

May	1	2	3	4	5	6	7	8	9	10	11	12	13	14	15	16	17	18	19	20	21	22	23	24	25	26	27	28	29	30	31
	X						X	X					X	X	X	X	X	X	X	X	X	X	X	X	X	X	X	X	X	X	

Jun	1	2	3	4	5	6	7	8	9	10	11	12	13	14	15	16	17	18	19	20	21	22	23	24	25	26	27	28	29	30	31
			X	X	X	X	X	X	X	X	X	X	X	X	X	X	X	X	X	X	X	X	X	X	X	X	X	X	X	X	

Initials _____ Name _____
 Dianna Accurso RN Pam Harmon
 Debbie Nickell RN

H = Holiday A = Absent
 I = Inservice Day O = Out of Medication
 X = No School