MEDICATION ADMINISTRATION FORM

Phone 605-334-7397 Fax 605-334-6928

This form should be completed by parents if their child must take any type of medication (prescription or non-prescription) or may need emergency medication, while at school. Medication must remain in the original pharmacy or manufacturer's container clearly marked with the student's name, medication name and dosage required. For your child's safety and the safety of other children, a parent must drop off/pick up any medication at the elementary office for children in Preschool through 5th grade.

All appropriate paperwork must be completed to allow school nurse or trained staff to administer any medication or for a student to carry and self-administer medication.

To be completed by Parent/Guardian (and Physician if for prescription medication) ANNUALLY:

Student's Name: _____ DOB: _____ Date:_____

Grade/Teacher: _____ Parent/Guardian Name:_____

Parent Contact: Home: _____ Wk: _____ Cell: _____ Email:_____

Diagnosis: _____ Allergies:_____

Name of Medication/Treatment:_____ Dosage/Amount to be given:_____

Time medication should be given: _____ Method of administration (by oral, eye drops, etc.):_____

Duration (beginning and discontinue date): _____ Possible Side Effects: _____

Any Special Instructions: _____

Option 1:_____ (initial) I request and authorize the school nurse or trained personnel at Sioux Falls Christian Schools to store and administer 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 patient's name and dosage of the drug to be taken (if prescription), or in the original packaging (if over-the-counter). I understand the school and individuals involved will not be held liable for any adverse effects of the medication. I give permission for communication that may be necessary between the prescribing physician and the school nurse to ensure safe medication administration for my child. In the event of a school-sponsored field trip, I understand that my child's scheduled and/or emergency medication will be sent with the designated personnel (typically the teacher) in the correct amount and labeled with the time to be administered during the activity, unless otherwise specified by me. I understand I am responsible to pick up unused medication when my child is finished with it, or within one week after the last day of school. Remaining medication will be disposed of if not picked up within one week after school is out.

Physician's Name (If prescription medication): _____ Phone Number:_____

Physician Signature (If prescription medication): _____ Date:_____

Option 2: _____ (initial) I request and authorize my child to keep and self-administer his/her own medication at school.This option is only available for 6th-12th graders,with the exception of EpiPens and inhalers for Kindergarten-5th grade. By choosing this option I relieve Sioux Falls Christian Schools and personnel of all responsibility associated with this self-administration. I understand this option is available only when it will not be a potential health risk to my child or others. **Except for inhalers and EpiPens, only medication for one day at a time may be brought to school and must be in the original labeled packaging (over-the-counter) or pharmacy labeled bottle (for prescription).**

Physician's Name (If prescription medication): _____ Phone Number:_____

Physician Signature (If prescription medication): _____ Date:_____

Student Signature: _____ Date:_____

**Please note it is mandatory for 7-12th graders to carry and be responsible for their medications for all extracurricular activities. If you have concerns about this please discuss with your student's coach.

Students are prohibited from transferring, delivering or receiving any medication to or from another student. All such violations, or use of medication for purposes other than intended use, will result in confiscation of the medication and discipline in accordance with SFC discipline policy.

Parent or Guardian Signature: _____ Date:_____