**THE LAPORTE SCHOOL**

 ISD#306

 315 MAIN STREET WEST

LAPORTE, MN 56461

218-224-2288

FAX 218-224-2905

Serving the communities of: Laporte - Benedict – Guthrie – Lake George – Kabekona

*An Equal Opportunity Employer/Educator*

**HARVEY M. JOHNSON KIM GOODWIN**

**SUPERINTENDENT PRINCIPAL**

**Laporte School Medication Policy**

If your child needs to take medication during school hours, the school district requires the following:

1. Parents must bring the medication to the health office. If the student is allowed to carry an Epi-pen or inhaler on their person, an additional emergency medication will be required for storage in the Health Office.
2. Written consent of parent/guardian requesting school personnel to give the medication as ordered by the licensed prescriber.
3. A written order from a licensed prescriber which includes the following:
	1. student name
	2. name and dosage of medication
	3. time to be given
	4. diagnosis (optional)
	5. possible  side effects (optional)
	6. how long medication needs to be given
4. The school must be notified immediately by the parent or student 18 years or older in writing of any change in the student’s prescription medication administration. A new medication authorization or container label with new pharmacy instructions shall be required immediately as well.
5. All medication must be brought to school in a pharmacy-labeled container.  School personnel may refuse to give medication sent to school in odd bottles, plastic baggies, envelopes, foil, etc.
6. Over-the-counter/non-prescription medications may only be given with written consent of parent/guardian and must be provided in an original container.
7. Students who will be self-medicating should provide the health office with a prescription or note from the licensed prescriber and written consent from the parent/guardian.

Thank you for your cooperation in helping us to provide safe medication administration for your child.

Please direct questions to the Health Office.

218-224-2288 Extension 108

***Our Mission:*** *To enable our students to acquire the knowledge, skills, and values for a lifelong process of learning, growth, and responsible citizenship in an increasingly interdependent world.*

School Board Members: Chairman George M. Taylor, Jr.; Clerk Scott Tammaro; Treasure Jim Day; John Seegmiller; Steven Ware; Cindy Doke; Joe Jorland

**LAPORTE SCHOOL HEALTH SERVICE**

**MEDICATION FORM**

**PRESCRIPTION MEDICATION:**

Parents of students requesting prescription medication to be given to their child during school hours by school staff are required to provide the school with the following information:

1) The licensed prescribers' order

2) Written parent consent

3) Medication must be supplied in the original pharmacy labeled bottle

Persons actually giving the medication will be designated by a school nurse.

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**Student Name Grade**

**\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ \_\_\_\_\_\_\_\_\_\_\_\_\_\_**

**Parent Name Phone**

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**LICENSED PRESCRIBERS ORDER:**

(A copy of the prescriber order may be attached here.)

I have prescribed the following medication for this child and request it be given during the designated school hours.

**\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ \_\_\_\_\_\_\_\_\_\_\_\_ \_\_\_\_\_\_\_\_\_\_**

**Medication Dosage Time**

**For treatment of: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**

**Special instructions: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**

**Possible side effects: (optional) \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**

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**Licensed Prescriber Signature: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Date: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**

**Physician Name: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Fax Number: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**

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**PARENT REQUEST FOR ADMINISTRATION OF PRESCRIPTION MEDICATION**

**\_\_\_\_\_**I request this prescription medication to be given as directed by the licensed prescriber.

**PARENT REQUEST FOR ADMINISTRATION OF NON-PRESCRIPTION MEDICATION**

**\_\_\_\_\_**I request this non-prescription medication to be given to my child.

Name of medication\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Dosage and time\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

For treatment of\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

How long to be given\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

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**Parent Signature:** **Date:**