Bowling Green R-I School District
700 West Adams Street
Bowling Green, Missouri 63334
www.bgschools.k12.mo.us
Phone: (573) 324-5441 Fax: (573) 324-2439
"Home of the Bobcats"

2018-2019 PRESCRIPTION MEDICATION FORM

I give permission for my child Name: _____
Grade: _____ DOB: _____to receive the following
_____, _____,
_____ medication(s) at school according to standard school policy and procedures. (JHCD, JHCD-AP)

In order to best serve the interest and health of the students in the Bowling Green R-I School District, the following recommendations should be followed in regard for medication that "needs" to be administered during school hours.

1. If possible medication(s) are to be given at **HOME**.
2. After starting a new medication he/she **MUST** be kept home for 24 hours to monitor for possible side effects/reactions.
3. When necessary for student to receive medication(s) while at school, the medication has to be sent in its **ORIGINAL** container with the pharmacy prescription label on the outside.
4. Medication time is during the student's lunchtime. We will only give medications at another time if specifically requested by the physician.
5. **ALL MEDICATIONS ARE TO BE BROUGHT TO SCHOOL BY THE STUDENT'S PARENT OR GUARDIAN. IF MEDICATION IS BROUGHT IN BY THE STUDENT, MEDICATION WILL BE HELD IN THE NURSES OFFICE AND PARENT WILL BE CALLED.**
6. I give permission for exchange of verbal and written communication between the physician and the school nurse regarding my child's medication regime while at school.

By signing below I verify I have read and agree to the statements above, school policy/procedure, and understand all that it entails.

Parent Signature: _____ Date: _____

Relationship to the Student: _____