SMSD
Health Services
Shawnee Mission School District

Medication Administration Guidelines

Permission: Written permission from the parent or guardian must be on file for all medications given at school, including over-the-counter (OTC) medications. Authorization must be renewed every school year.

Medication: Only FDA approved prescription and OTC medications are allowed to be administered by school personnel. OTC medications will be given per package label dosing instructions, unless prescribed by a physician.

Container: Prescription medication brought to school must be in the original container with a current prescription label on the bottle including the child's name, doctor's name, date, medication name, dosage, and time to be given. Controlled substances must be submitted with a Medication Count Form. OTC medications provided by parent must be in the original container and labeled with the student's name.

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Medication Permission Form

Student Name: D.O.B.: Grade: School Yr:

Over-The-Counter Medication

By initialing below, I give permission for school personnel to administer the following medication(s) as needed to my student for minor discomfort or injury. Medications supplied by school may vary between buildings and grade levels.

_____ Acetaminophen (Tylenol)
_____ Ibuprofen (Advil or Motrin)
_____ Cough drop (non-medicated)
_____ Eye drop (non-medicated lubricating)
_____ Antihistamine oral (diphenhydramine, cetirizine)
_____ Antihistamine allergy eye drops
_____ Antacid (Tums)
_____ Topical medication (antibiotic ointment, calamine lotion, hydrocortisone cream)

Parents may also supply other over-the-counter medications. Please list below:

Medication name: _____ Dosage: _____
Reason given: _____ Time: _____

Medication name: _____ Dosage: _____
Reason given: _____ Time: _____

Prescription Medication

Medication name: _____ Dosage: _____
Reason given: _____ Time: _____

Medication name: _____ Dosage: _____
Reason given: _____ Time: _____

On early dismissal or late start days please indicate one of the following:
_____Do NOT administer medication on early dismissal days
_____Do NOT administer medication on late start days
_____Administer medication at adjusted lunch time
_____Administer medication at prescribed time

To ensure continuity of care, I give permission for the school nurse to communicate with my student's healthcare provider regarding medication administration at school.

Physician Name: Phone number

Physician Signature (required if no Rx label): Date

School personnel who administer medication according to proper dosing instructions shall be held harmless for any adverse reaction experienced by the student. My student has previously taken the medications(s) listed above with no known adverse reaction.

Parent/guardian Name:

Parent/guardian Signature: Date

Revised 8/18/2015