

**Keota Community Schools  
Medication Policy and Request Form**

**PLEASE DO NOT SEND ANY MEDICATION TO SCHOOL UNLESS ABSOLUTELY NECESSARY.**

**PRESCRIPTION DRUGS** must be brought in the original bottle with prescription label intact, with **name of the student, name and strength of the drug, amount and time to be given, route of administration, date ordered, and name of the healthcare provider.** Label must be current. (often drug stores will provide a second bottle to be used at school if requested). All medications should be taken for the full time prescribed, especially antibiotics.

**NON-PRESCRIPTION DRUGS** must be brought in the original container, with label and directions intact. Student's name must be written on the container with a marker. This category includes: cough medicines, ointments, etc. The school has the right to refuse to give over the counter medications. Most can be given before school and right after school. They will not be given for more than 5 times without written authorization from a healthcare provider. The recommended dosage on the package will not be exceeded.

**TYLENOL AND IBUPROFEN** will be supplied by the school district on an as needed basis only. Parents have the option of signing permission for Tylenol and/or Ibuprofen during registration each school year. A supply of Tylenol and Ibuprofen will be kept at each building. These medications will not be given more than 5 times without written authorization from a healthcare provider.

**HERBAL SUPPLEMENTS AND VITAMINS** will not be given at school without written authorization from a healthcare provider and must be brought in the original container, with label and directions intact. Students name must be written on the container with a marker. Information sheet must be provided stating uses, warnings, and possible side effects. The school has the right to refuse to give herbal supplements and vitamins. Most can be given before school and right after school.

A request form with parent signature must accompany all medications brought from home. Medication not in the original container or accompanied by a signed request form will not be given. Medication that is sent to school in **BAGGIES or ENVELOPES** will not be given. Medication will not be given with another person's name on the label. Please remind your child that he/she is responsible to come to the office for their medication when it is time.

The school shall have the right to contact the prescribing healthcare provider to confirm or clarify medication instructions.

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**PERMISSION TO DISPENSE MEDICATION DURING SCHOOL HOURS**

Student \_\_\_\_\_ Grade \_\_\_\_\_ Date \_\_\_\_\_

Medication \_\_\_\_\_ Prescription # \_\_\_\_\_

Dosage \_\_\_\_\_ Time to be given \_\_\_\_\_

Date to begin \_\_\_\_\_ Date to end \_\_\_\_\_

Diagnosis \_\_\_\_\_

Direction for Administration or Storage \_\_\_\_\_

Possible Side Effects \_\_\_\_\_

Any Allergies? \_\_\_\_\_

Any Special Directions? \_\_\_\_\_

Parent/Guardian Signature \_\_\_\_\_ Phone # \_\_\_\_\_

**PHYSICIAN SIGNATURE** \_\_\_\_\_ **Phone #** \_\_\_\_\_

Asthma Inhalers will be \_\_\_\_\_ Kept and administered in the Office  
\_\_\_\_\_ Kept by student and administered as needed  
\_\_\_\_\_ Kept by student and administered as needed but will have extra inhaler in the office.

**FOR SCHOOL USE ONLY**

Student Name \_\_\_\_\_ Grade \_\_\_\_\_  
Medication Name \_\_\_\_\_ Dosage \_\_\_\_\_  
Amount to be given \_\_\_\_\_ Time to be given \_\_\_\_\_  
(If medication is long term – attach Monthly medication record if short-term record below.)

# of Days	DATE	TIME	DOSAGE	PERSON GIVING MEDICATION (Sign once then initial)
1				
2				
3				
4				
5				

**DOCTOR SIGNATURE NEEDED TO CONTINUE GIVING OTC MEDICATION  
(SEND MEDICATION HOME WITH BLANK REQUEST FORM)**

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