NACS GUIDELINES AND CONSENT FOR MEDICATION AND TREATMENT ADMINISTRATION

These Guidelines are for all Prescription Medications/Treatments and Nonprescription (Herbal-Vitamin-Dietary) Medications/Treatments

- All medications must be brought to school and taken home by a parent/guardian.
- All medications must be kept locked in the clinic during the school day, with the exception of inhalers and Epi-pens. A child may carry and self-administer these prescribed medications if the nurse has written permission by a physician.
- When possible, schedule doses of medications to be given at home and not at school.
- NACS is not responsible for adverse reactions of medications when given according to the physician's or manufacturer's instructions.
- All medications must be in the original container with a label and child's name printed or written on it.
- Send only the amount of medication needed at school, keep the remainder at home in another container.

I will comply with the above guidelines and I give permission to the school nurse, or school personnel designated by the nurse, to give the medication/treatment listed below. I give permission to the school nurse to share with the appropriate school personnel information relative to the medication/treatment, e.g. adverse side effects, as he/she determines necessary for my child's health and safety.

Child's Name_____ Grade_____ Date of Birth_____

Diagnosis for which medication/treatment is ordered_____

Name of medication/treatment_____

Dose to be given_____ Time to be administered_____

Date to start medication/treatment _____Date to stop medication/treatment_____

Form of medication/treatment: Tablets/capsule_____Liquid_____Inhaler_____Injection_____

Nebulizer_____ Other _____

If medication is an Inhaler or Epi-Pen, this student may carry the medication Yes _____ No_____

Additional comments _____

I want my child to receive his/her medication on days when school is delayed. Yes_____ No _____

Date _____ Parent/Legal Guardian Signature _____

Physician's Name *(printed)* _____

Physician's Signature_____

(Required for Prescription Medications)