

## **Administering Medicines to Minor Pupils**

Adrian Public Schools personnel are prohibited from providing or administering any medication to a pupil, except as authorized by Board Policy JHCD and accompanying regulation JHCD-R.

- 1. Medication may be administered by a school administrator or designee in the presence of another adult in accordance with Section 380.1178 of the School Code.
- 2. The parent or guardian has furnished the school district this form completed by the parent and physician. **Authorization must be updated annually or for each new prescription.**
- 3. All medication must be in a current labeled container as prepared by a pharmacy, physician or pharmaceutical company and labeled with dosage and frequency of administration.
- 4. The school will **not** divide pills in half or provide measuring utensils.
- 5. Nothing in this policy is to prohibit school personnel from the administration of emergency first aid.
- 6. Medication will be administered every school day, including half days.

## Adrian Public Schools – Physician's order Request for administration of medication to minor pupils

Please Print)				
Student Name:	Address:	DOB:	Grade:	
Condition for which drug is being adminis	stered:			
Does child require medication be given of	uring school hours? □Yes □No	Y		
Name of	Form of	Other (explain)		
Drug:	Medication: □Injection □Inhaler			
Amount to	Special Instructions:			
be given:				
Time of	Medication will be administered at a designa	cation will be administered at a designated time between the hours of		
Administration:	11:00-1:00 unless special arrangements are			
Route or □Right ear □ Right eye □	Oral □Inhaler - May student carry	inhaler? □Yes □No		
location: ☐ Left ear ☐ Left eye ☐	Other (explain)			
Relevant side effect or adverse				
reactions to be observed, if		· ·		
any:		· · · · · · · · · · · · · · · · · · ·		
List minimal frequency between doses (	especially if p.r.n.):			
If p.r.n., list symptoms/conditions under v	vhich medication is to be given:			
Length or time during which medication	shall be administered: From			
То		(D-4-)		
Date Physician Name (please	print) Physician Signature (Date)	(Date)		
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## **Parent Permission**

nereby give permission to the Adrian Public Schools Staff to administer medication to my child as indicated above by the empleted Adrian Public Schools - Physician's Order, Request for Administration of Medication to Minor Pupils and for the hysician('s)/staff and school district staff to share information needed to assist my child with medication needs.

Date	Parent Signature	Phone