Department of Defense Dependents School
Patch High School
Office of the School Nurse

Permission for Student to Retain Control of Medication

(All three sections must be completed and signed.)

Section 1 (To be completed by physician)

Name of student_____ Age_____ Grade_____

Diagnosis_____ Duration of treatment_____

Medication(s), dosage and route_____

_____

Times of day/circumstances under which medication is to be given:
_____

Reason student must have possession of medication(s) at all times:
_____

Expected results from using the medication(s):
_____

Expected time frame to achieve results following medication administration:
_____

What student should do if the expected results are not obtained in the specified time frame:
_____

I have instructed the student and the student's parent in the proper use and method of administering this medication and the legal consequences of using the medication inconsistently with the prescription or of sharing the medication with anyone else. I have provided the student and his/her parents with the following instructions regarding the symptoms of possible adverse reactions, contraindications, and what to do if student experiences difficulty with or while taking the medication:

_____

_____

The student's medical condition is such that the student must be in possession and control of the medication at all times and be free to administer the medication when needed. **In my opinion, the student possesses sufficient maturity and responsibility to follow my instructions.**

Physician's signature: _____ Phone: _____ Date: _____

Section 2 (To be completed by parent)

Name of parent(s)_____
Home phone_____ Work phone_____ Cell Phone_____

I have read the physician's statement and hereby consent to my child's retaining possession at all time of the above prescribed medication. I understand, and have informed my child, that any illegal use of the medication by the student (including the use of the medicine inconsistent with the prescription or sharing the medication with another) will result in disciplinary action. **During school hours my child has been instructed to take his/her medication in the nurse's office. I will provide extra medication to be kept in the school nurse's office as backup for the one carried by my child.**

Parent's signature_____ Date_____

***Section 3 (To be completed by student)**

I understand that I am required to retain possession and control of my prescribed medication in accordance with the terms set forth in Section 1 above. **I have been advised of my responsibility to use my medication only in strict accordance with the prescription.** I understand that any use of my medication inconsistent with the terms of my prescription is an illegal use, as is the sharing of my medication with another person. I agree to carry a pharmacy-labeled container of the medication, to keep a record of the times I use my medication, and to share the information with the nurse/instructor/coach who will help evaluate and monitor the effects of my medication. **During school hours I will take my medication under the supervision of the school nurse or the person designated by the school nurse and the school administrator.**

Student's signature_____ Date_____

***Guidance on the age of the student who signs this form needs to be obtained prior to its use.*

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MEDICATION DURING SCHOOL HOURS

Erlaubnis fur Medikamentengabe

TO BE COMPLETED BY PHYSICIAN:

Name of Student *Des Schulers/Schulerin*_____

Diagnosis/Indication for Medication Administration_____

Medication *Medikament*_____Dosage *Dosierung*_____

Time *Tages Zeit* _____ Route_____

Duration *Dauer der Behandlung*_____

Possible Side Effects *Moglishe Nebenwirkungen*_____

Precautions/Restrictions_____

Other Medications Taken *Werden andereMedikamente*_____

_____ _____
Signature of Physician *Unterschrift des Arztes* Date *Datum*

Clinic_____Phone_____
Telefonummer des Arztes

TO BE COMPLETED BY PARENT:

I hereby give my permission for _____ to receive, from the school nurse and/or other trained school personnel, the above prescription at school as ordered. I understand that it is my responsibility to furnish the school with this medication. I give permission for the school nurse and health care providers at the medical treatment facility to exchange information about my child, the diagnosis for which this medication is prescribed, and my child's response to the medication.

_____ _____
Signature of Parent/Guardian Date

Parent daytime phone number(s)_____

Parent e-mail address_____

NOTE: *The prescription medication must be brought to school in the original container, properly labeled by the pharmacy or physician, stating the name of the student, the medication, the dosage, and current date. The medication will remain at school for the duration of the prescription.*