CLAYTON RIDGE COMMUNITY SCHOOL DISTRICT

Clayton Ridge Elementary
131 S River Park Drive
Guttenberg, IA 52052

Clayton Ridge Middle School
502 W Watson St.
Garnavillo, IA 52049

Clayton Ridge High School
131 S River Park Drive
Guttenberg, IA 52052

Request For Medication To Be Given At School
(oral medications, ointments, eye drops, etc)

(Prescriber to complete and sign)

Student Name: _____ Birthdate: _____ Grade: _____
Name of Medication: _____ Reason for medication: _____
Instructions: Size of dose: _____ Time to give: _____
Size of dose: _____ Time to give: _____
Additional instructions: _____
This order is in effect for this school year unless otherwise indicated. Yes _____ Other _____
Please list any anticipated reactions / side effects of the medication: _____
In the event of a 2 hour delayed start, medication that is normally scheduled for 8:00 a.m. shall:
_____ Still be given upon student arrival to school (between 10:00 and 10:30)
_____ NOT be given at school (morning dose will be given at home)

Prescriber's Signature _____ Date _____

(Parent / Guardian to read and sign)

I request the above stated medication be given to the above student according to school policy. Medication will be supplied in its original, properly labeled container. I will notify the school nurse in writing of any changes.
If your child is taking daily medication at home as well, please list medications, dose, time taken, and reason for taking:
_____

Parent / Guardian Signature _____ Date _____

Authorization – Asthma or Airway Constricting Medication
Self-Administration Consent Form (EpiPen or Inhaler)

(Prescriber to complete and sign)

Student Name: _____ Birthdate: _____ Grade: _____
Name of Medication: _____ Reason for medication: _____
Dosage: _____ Route: _____
Time to be given: _____
Administration Instructions: _____
Prescriber's Signature: _____ Date: _____
Prescriber's Address: _____
Prescriber's Phone: _____

(Parent / Guardian to read and sign)

- I request the above named student possess and self-administer asthma or other airway constricting disease medication(s) and/or an epinephrine auto-injector at school and in school activities according to the authorization and instructions.
- I understand the school district and its employees acting reasonably and in good faith shall incur no liability for any improper use of medication or an epinephrine auto-injector or for supervising, monitoring, or interfering with a student's self administration of medication or use of an epinephrine auto-injector. I acknowledge that the school district is to incur no liability, except for gross negligence, as a result of self-administration of medication or use of an epinephrine auto-injector by the student.
- I agree to coordinate and work with school personnel and notify them when questions arise or relevant conditions change.
- I agree to provide safe delivery of medication and equipment to and from school and to pick up remaining medication and equipment.
- I agree the information is shared with school personnel in accordance with the Family Education Rights and Privacy Act (FERPA) and any other applicable laws.
- I agree to provide medication approved in this form.

Parent/Guardian Signature: _____ (Agreed to above statements) Date: _____

For inhaler use: ____ Inhaler will be kept at school in the nurse's office
____ Student will carry inhaler
____ Student will bring inhaler only if needed

For EpiPen:____ EpiPen will be kept at school in nurse's office
____ Student will carry EpiPen
____ Other _____