Linn-Mar Community School District
Medication Permission Form

Code 504.31-E1

To insure compliance with Linn-Mar Board policy for administering medication at school, the following procedures must be followed:

- **ALL MEDICATION MUST BE DELIVERED TO AND FROM SCHOOL BY PARENT/LEGAL GUARDIAN IN THE ORIGINAL AND PROPERLY LABELED CONTAINER.** The container must include the following information: student name, medication, dosage, time, route and physician. Written authorization and instructions must be provided by parent/legal guardian for all medication. The school nurse shall have the right to contact the prescribing physician to confirm or clarify medication instructions. The time of medication administration may need to be altered slightly to fit your student's schedule.
- For preschool through 5th grade students, a physician/dentist signature is required before any non-prescription, over-the-counter medication will be given. This includes Tylenol, Advil, cough medicines, etc.
- High school and middle school students (Grades 6-12), in accordance with Health Services protocols for common complaints of pain or illness, may have limited, over-the-counter medication with written parental consent.
- All medications administered will be provided by parents. Linn-Mar Health Services will not provide medications.
- If any medication remains after the last day of school, it will be discarded within 24 hours per federal and state law.

Student Name _____ Grade _____

Medication _____ Dosage _____ Time _____

Start Date _____ End Date _____ For _____ (health condition)

Parent/Guardian Signature _____ Date _____

Physician signature required for non-prescription medications for students in preschool-5th grade.

Physician Signature: _____ Date _____

CONSENT FOR RELEASE OF INFORMATION: I give permission for the parties named below to exchange written and verbal information with personnel at LMCSD regarding the above-named student. If this medication is for attention or behavior concerns, LMCSD may send behavior checklists to the physician named below. This permission is for one school year.

Specific authorization for release of information protected by state or federal law:
My signature releases all information related to (check appropriate spots):

____Mental Health/Psychological ____Substance Abuse ____Allergies ____Asthma

Other (Specify) _____

Physician/Facility _____ Phone_____

Parent/Guardian Signature _____ Date _____

Reviewed 7/15/13 **Revised** 10/14; 4/16; 10/17