

RIVERMONT COLLEGIATE

1821 Sunset Drive, Bettendorf IA 52722 563-359-1366 Fax 563-359-7576

This form must be completed in order for any school personnel to administer medication (prescription or non-prescription) during the school day. Please submit this form along with the medication – which must be marked clearly with the student’s name and be in the original manufacturer’s container or labeled prescription bottle – to Ms. Bonnie Campbell in the mansion for Middle and Upper School, and to Mrs. Sue Johnson in Becherer Hall for Lower School and Early Childhood.

This form is also to be used to allow a student to self-administer asthma medication during the school day, and to carry said medication with them. Asthma medication is the only medication that can be self-administered by a student.

Only ONE medication per form, please.

**PHYSICIAN’S AUTHORIZATION FOR STUDENT MEDICATION WHILE AT SCHOOL:**

**This section to be filled out by Physician**

Patient’s name: Last First Middle Date of Birth Grade

Physician: Please check one: \_\_\_\_\_ This medication is to be administered by school staff during the school day.

OR \_\_\_\_\_ This medication is an asthma medication which the student will carry with them. ONLY asthma medication may be self-administered during the school day.

Medication Dosage Route Time to be given at school

Additional instructions or directives

Beginning Date Ending Date/re-evaluate/follow-up date

Purpose of medication

Signs to observe or side effects

Physician’s signature Date

Physician’s address and emergency phone

**PARENT’S REQUEST REGARDING STUDENT MEDICATION WHILE AT SCHOOL (CHOOSE ONE)**

\_\_\_\_\_ I request that the medication listed above be administered by school personnel to my student during the school day. The information is confidential according to the Family Education Rights and Privacy Act, and only school personnel needing to know will have access to the information. I agree to coordinate and work with school personnel and the prescriber when questions arise. I agree to provide safe delivery of medication and/or equipment to and from school, and to pick up remaining medication at the close of the school year.

Parent Signature Date Daytime contact information

OR

\_\_\_\_\_ I request that school personnel permit my child to self-administer asthma or airway constricting medication as stated by the physician above. I acknowledge that Rivermont Collegiate is to incur no liability, except for gross negligence, as a result of self-administration of medication by the student as established by Iowa Code 280.16.

Parent Signature Date Daytime contact information