DAVENPORT COMMUNITY SCHOOLS

HEALTH SERVICES
MEDICATION ADMINISTRATION CONSENT

School _____
Fax# _____

To the Parent or Guardian:

We advise you that the Davenport Community School Health Services Department does not normally administer or take any responsibility in the giving of medication to school children. If your child is on any medication, please give it at home and advise the school so the staff may watch for adverse side effects of the drug. However, if a medication must be given during school hours, the school must have the name of the drug, dosage, hour to be given and for how long, signed by the attending physician.

The medication must be maintained in the original prescription container which shall be labeled with:

1. Name of pupil
2. Name of medication
3. Directions for use
4. Name of physician
5. Name and address of pharmacy
6. Date of prescription

Medication orders are only effective for the school year in which they are ordered. The physician must renew them each school year. Also the diagnoses and the ICD 10 code are needed for Medicaid billing.

Since it is necessary that my child be given medication during school hours, I hereby give my permission for the Health Provider to provide the ICD 10 Code to the school and certified school personnel to administer it.

_____ _____ _____
Student's Name Birth date Parent / Guardian Signature

Diagnosis _____ **ICD 10 Code:** _____

Name of Medication _____

Dosage _____

Time to be given _____

Reason _____

Anticipated Reactions _____

If this is medication for asthma, please attach the Student Asthma Action Plan.

_____ _____
Date Physician's Signature

EPI-PENS and ASTHMA MEDICATIONS ONLY

If you and your physician feel your student needs to carry their own epi-pen or asthma inhaler with them during school hours, you must have your physician sign this order sheet for them to do so. Except in an instance of gross negligence, the school district and its employees will incur no liability as the result of any injury arising from self-administration of medication by a student.

I feel this student is adequately educated in the appropriate use of his/her epi-pen or inhaler and is responsible to self-administer medication as needed.

_____ _____
Parent's Signature Physician's Signature

RETURN THIS FORM TO THE STUDENT'S SCHOOL **Revised 12/2016**