



Administering Medicines to Minor Pupils

Adrian Public Schools personnel are prohibited from providing or administering any medication to a pupil, except as authorized by Board Policy JHCD and accompanying regulation JHCD-R.

1. Medication may be administered by a school administrator or designee in the presence of another adult in accordance with Section 380.1178 of the School Code.
2. The parent or guardian has furnished the school district this form completed by the parent and physician. Authorization must be updated annually or for each new prescription.
3. All medication must be in a current labeled container as prepared by a pharmacy, physician or pharmaceutical company and labeled with student name, dosage and frequency of administration.
4. The school will not divide pills in half or provide measuring utensils.
5. Nothing in this policy is to prohibit school personnel from the administration of emergency first aid.
6. Medication will be administered every school day, including half days.

Adrian Public Schools – Physician's order Request for Administration of Medication to Minor Pupils (Please Print)

Name:	Address:	DOB:
Condition for which drug is being administered:		
Does child require medication be given during school hours? <input type="checkbox"/> Yes <input type="checkbox"/> No		
Name of Medication:	Form of Medication: <input type="checkbox"/> Tablet/Capsule <input type="checkbox"/> Nebulizer <input type="checkbox"/> Injection <input type="checkbox"/> Inhaler <input type="checkbox"/> Liquid <input type="checkbox"/> Other (explain)	
Amount to be given:	Special Instructions:	
Time of Administration:	Medication will be administered at a designated time between the hours of 11:00-1:00 unless special arrangement are made with principal.	
Route or location:	<input type="checkbox"/> Right ear <input type="checkbox"/> Right eye <input type="checkbox"/> Oral <input type="checkbox"/> Inhaler - May student carry inhaler? <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Left ear <input type="checkbox"/> Left eye <input type="checkbox"/> Other (explain)	
Relevant side effect to be observed, if any:		
Length or time during which medication shall be administered: From _____ To _____ (Date) (Date)		
Date	Physician Name (please print)	Physician Signature
		Phone

Parent Permission

I hereby give permission to the Adrian Public Schools Staff to administer medication to my child as indicated above by the completed Adrian Public Schools - Physician's Order, Request for Administration of Medication to Minor Pupils.

Parent Signature	Phone
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