2022-2023 PRESCRIBED AND OVER-THE-COUNTER MEDICATION PROFILE

Parent Name _____

Student Name _____

MEDICATION INFORMATION

Please complete this form if your child will require prescription, over-the-counter, or emergency medications/treatments at any time while at Mainspring Academy.

MEDICATION 1

Name of medication _____

Purpose of medication _____

Medication dose _____

Medication Type (Choose One): ☐ **Prescription** ☐ **Over-the-counter** ☐ **Emergency**

Medication Frequency (Choose One): ☐ **Daily** ☐ **As needed** ☐ **Emergency**

If daily, preferred time to administer (Choose One) ☐ **9:30am** ☐ **10:30am** ☐ **11:30am** ☐ **12:30pm** ☐ **1:30pm** ☐ **Before Meal**

Does the medicine need to be taken with food or water? List _____

How long will your child need to take this medication? _____

Please list any additional directions, if applicable _____

_____

_____

MEDICATION 2

Name of medication _____

Purpose of medication _____

Medication dose _____

Medication Type (Choose One): ☐ **Prescription** ☐ **Over-the-counter** ☐ **Emergency**

Medication Frequency (Choose One): ☐ **Daily** ☐ **As needed** ☐ **Emergency**

If daily, preferred time to administer (Choose One) ☐ **9:30am** ☐ **10:30am** ☐ **11:30am** ☐ **12:30pm** ☐ **1:30pm** ☐ **Before Meal**

Does the medicine need to be taken with food or water? List _____

How long will your child need to take this medication? _____

Please list any additional directions, if applicable _____

_____

_____

2022-2023 MEDICATION PERMISSION FORM

Parent Name _____

Student Name _____

MEDICATION AGREEMENT

I UNDERSTAND IF MY CHILD REQUIRES PRESCRIPTION, OVER-THE-COUNTER, OR EMERGENCY MEDICATION/TREATMENT DURING THEIR TIME AT MAINSPRING ACADEMY, THE FOLLOWING RULES MUST BE OBSERVED (Initial):

_____ A medication profile must be completed for each treatment to be administered. This form serves as my consent for Mainspring Academy to administer the medication to my child.

_____Med-certified staff at Mainspring Academy must be notified regarding any changes to my child's treatment.

_____Medication must be given to med-certified staff in its original form, affixed with a pharmacy label which includes medication, pharmacy, and clinic details.

_____ Med-certified staff can only administer treatment as specified on the pharmacy label.

_____ Medication must be stored in the locked nurse's station. It may not be stored in the classroom.

_____ If my child's medication is to be discontinued, I must complete a take-home consent form.

_____ I am responsible for refilling my child's medication in a timely manner and ensuring the school has an adequate supply.

_____ If my child takes his/her medication with pudding, applesauce, flavored drinks, or via any other alternative methods, I am responsible for providing a supply for the school and promptly refilling it as needed.

_____ I am responsible for collecting my child's medication prior to breaks, intersessions, and long school closures.

_____ I am responsible for replacing expired medications.

_____ Medication will be disposed of if med-certified staff do not receive a response to 3 repeated communications to collect my child's medication.

_____ If staff has to use my child's emergency medication, depending on the severity of the related emergency, my child may not return to school until I can provide a replacement for the treatment.

_____There shall be no liability for civil damages as a result of the administration of such medication when the person administering such medication acts as a reasonable prudent person would act under the same circumstances.

I HEREBY CONSENT FOR MY CHILD TO TAKE THE MEDICATION THAT I AM PROVIDING, AUTHORIZE THE SCHOOL TO STORE THESE MEDICATIONS ACCORDING TO SCHOOL POLICIES, AND ADMINISTER THE MEDICATION TO MY CHILD AS DIRECTED. I FURTHER AGREE TO INFORM MAINSPRING ACADEMY OF ANY CHANGES IN TREATMENT, INCLUDING ANY REACTION TO THE MEDICATION. I FURTHER UNDERSTAND THAT THIS CONSENT APPLIESTO ALL MEDICATION, WHETHER IT IS PRESCRIBED OR PURCHASED OVER THE COUNTER WITHOUT A PRESCRIPTION. I UNDERSTAND THAT THIS CONSENT IS VALID FOR ONE YEAR FROM THE SIGNED DATE.

Parent Signature_____Date_____