Cedar Falls Community Schools
1002 West First Street, Cedar Falls, Iowa 50613
Phone: 319-553-3000 Fax: 319-277-0614
Web Site: www.cfschools.org

Educating each student to be a lifelong learner and a caring, responsible citizen

Medication – Parent Permission Form

Dear Parent or Guardian,

Medications and treatments will be administered during *school hours only*, and not before or after *approved time of arrival/departure* school hours. Medications and treatments will ONLY be administered with documented authorization and instructions as provided by the parent or guardian. For student safety, a parent/guardian/or responsible adult must bring medications to school and should not be sent with the student.

Students may possess ONLY medications with proper documentation by the Nursing Services staff.
In order to comply with the Iowa Administrative Code, the following information must be clearly labeled on the original container/bottle:

1. Student name
2. Name of medication
3. Strength and Dosage
4. Frequency
5. Provider's (Prescriber's) name for prescriptions

- All prescription medication must be brought to school in its most current labeled container.
- All over-the-counter medications provided by the parent/guardian must be in an unopened container. Age appropriate directions will be followed as labeled unless accompanied by a Provider order indicating other dosage/directions.
- Herbal supplements cannot be administered per the Iowa Code.
- Medications and products containing aspirin will not be given at school without a Provider order.
- Parents/guardians must notify the RN/ health office of any changes with treatments, medication, dosage, strength, or instructions and complete a new Medication-Parent Permission Form. We cannot rely on messages from students or building staff/teachers. Changes will not be completed without parental permission.

This completed and signed form MUST be returned before medication/treatments will be administered.

Student Name: _____ DOB: ____/____/____

Name of medication: _____ Strength: _____ Dosage: _____

Time of day: _____ AM: ☐ PM: ☐ Frequency: _____

Prescriber: _____ Special Instructions: _____

Duration: School year: ☐ Other: ☐ Explain other: _____

This is a NEW medication for this student, and they have NOT received it before: Yes ☐ No ☐ (if no, see next line below)

☐ The student has received this medication before (if side effects were experienced, please list below): ☐ No known side effects

Other important comments and/or side effects from previous administration : _____

Special Circumstances arise from time to time; if applicable, indicate below as well as how to administer medications during these times (initial on lines below to indicate your understanding of this policy).

____ Late morning administration at school may impact timing of a noon dosage (if applicable).

____ Early dismissal medication policy: Medications regularly scheduled are to be given until dismissal time unless otherwise instructed (noted on reverse side) by parent/guardian or Medical Provider.

(TURN OVER →)

Late start (due to weather):
☐ I will administer A.M. dose at home
☐ Administer dosage upon arrival at school

Late arrival (for any other reason):
☐ I will administer A.M. dose at home
☐ Administer dosage upon arrival at school

Early dismissal (for any reason):
☐ I will administer Noon/PM dosage at home
☐ Administer dosage at school prior to dismissal

Comments: _____

Discontinued and remaining medication(s); non-emergent medications will ***NOT*** be sent home with a student.
A parent/guardian must pick them up at the health office:

- within 30 days of medication being discontinued
- at the end of the school year to avoid disposal

Emergency medications (defined as Epi-pen, inhaler, Diastat, Glucagon and diabetic supplies) may be sent home with a student with parent/guardian written permission (see below).

Parental/Guardian Permission: Please initial each item below for which you give permission:

____ I give permission for the above medication to be given to my student as instructed above by qualified staff.
____ The above student has not experienced any known previous side effects from this medication.
____ I further agree that school personnel may contact the prescriber as needed and that medication information may be shared between the provider and school personnel.
____ I understand the law provides that there shall be no civil damages as a result of the administration of medication shared with school personnel on a need-to-know basis where the person administering the medication acts as an ordinarily, reasonably prudent person would, under the same or similar circumstances.
____ I agree to notify/inform the health office of any changes with medication or care.
____ I agree to provide safe delivery of medication and equipment to and from school.
____ I agree to pick up remaining medication and equipment at the end of the school year, and within 30 days of medication / equipment being discontinued.
____ I understand if I do not pick up medications/equipment that it will be properly disposed of by health office staff.
____ For EMERGENCY MEDICATIONS ONLY- I give permission for the above medication to be given to this student for transport home at the end of the school year.
____ By signing below, it is agreed that I, the parent/guardian, have read the contents of this form and understand my responsibilities. I accept responsibility for performing the tasks. If at any time I have questions or desire additional information, I understand that it is my responsibility to contact the health office to request them.

Electronic Signatures. The exchange of copies of this Agreement and of signature pages by facsimile transmission (whether directly from one facsimile device to another by means of a dial-up connection or whether mediated by the worldwide web), by electronic mail in portable document format or pdf form, or by any other electronic means intended to preserve the original graphic and pictorial appearance of a document, or by combination of such means, shall constitute effective execution and delivery of this Agreement as to the parties hereto and may be used in lieu of the original Agreement for all purposes. Signatures of the parties hereto transmitted by facsimile shall be deemed to be their original signatures for all purposes.

_____ Parent/Guardian Signature

_____ Printed Name

_____ Relationship to Student

(_____)_____-_____ Current Phone Number

_____ Date

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