

MEDICATION POLICY

Dubuque Lutheran School follows guidelines set forth by the state health department and the Dubuque District Medication Policy. The policy for prescribed and over-the-counter medication is as follows:

1. Only prescribed medication (this includes over-the-counter medications) by a physician will be administered.
2. A school nurse or qualified school staff will administer the medication only with written authorization and instruction from the physician.
3. The medication must be delivered to school by the parent/guardian, unless other arrangements are made with the administration.
4. The medication must be in the original container. (You may want to ask for two labeled containers at the pharmacy.)
5. The following information must be on the medication container:

- Name of medication
- Dosage
- Time medication is to be given
- Name of physician prescribing medication
- Name of student
- Route of administration (by mouth)

*The bottom portion of this page must be completed and returned to school for your child to have the medication administered during school. This form may be taken with you when you visit the doctor. *

*Note**: _The doctor's signature is required for ALL medication _*and the forms need to be filled out at the doctor's office.

REQUEST FOR MEDICATION TO BE GIVEN AT SCHOOL

I request that medication be given by the school nurse or qualified personnel to:

Name of student_____

Medication_____

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* *First dose Dose _____mg Time_____

Second dose Dose _____mg Time_____

Third dose Dose _____mg
Time_____

Length of time medication will be required: School
year_____Other_____

For what purpose has the medication been prescribed?

Is the before school dose given at home? _____ or school?

Additional
Instructions_____

To comply with the Iowa Administration Code Section 41.12(11) entitled "Medication Administration," a physician's description of anticipated reactions of the student to the medication must be filed at school. Please list any anticipated reactions:

* _____
* _____
* _____*

(Signature of Physician) (Date)

(Signature of Parent or Guardian) (Date)

* / _ _ / *

* / _ This completed form must be at school before any medication will be given. _ / *