Updated 3/28/22

Guidelines for Medications at KIPP Columbus

- Medication Authorization Form must be completed and signed by both the parent/guardian and the healthcare provider before returning to school Nurse.
- A new Medication Authorization Form must be completed each school year AND when the medication or dose has changed.
- One Medication Authorization Form must be completed for each medication.
- Medications must be brought in the original container in which it was dispensed from the pharmacy and be labeled with the correct medication, dose, and instructions.
    - Label must match what is on the Medication Authorization Form,
    - The pharmacy can provide two separate labeled bottles for medications that are given both at home and at school.
    - Students using an inhaler, epinephrine pen or other emergency medications at school can request 2 prescriptions from their healthcare provider.
- Over the counter medications can be provided at school ONLY if a Medication Authorization Form is completed by both the parent/guardian and the healthcare provider.
    - Examples: Tylenol, ibuprofen, ointments, etc.

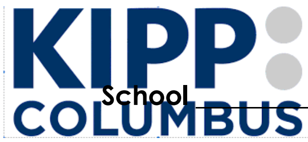
All unused medications must be picked up by the parent/guardian on the last day of school or it will be discarded

Questions: Contact your School Nurse:
614-966-3419 (KCP) 614-966-3416 (KCEM) 614-966-3417 (KCH)

Medication Authorization - One medication per form

Student Name____________________________ **Date of Birth** ___________ **School Year** _____________

Updated 3/28/22



Home Address: ____________________________ School ________________ **Grade** ___________________

Health Care Provider to Complete

I verify the above student should receive this medication at school for treatment of _____________________________

Medication ____ Dose ________________ Route ____________________

Administration Time(s) __________________________________ Special Storage Instructions ______________________

Start date for medication ________________________________ End date ____________/End of school year

Specific instructions for administration ____

Possible side effects of medication ____

Other medications prescribed to student (home and school) ____

Healthcare Provider Signature ____ **Date**______________________

Provider Name ____

Provider Address ____

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Phone __________________ Fax _________________

Parent/guardian Section

I hereby request and give my permission to the Board approved personnel to administer the above stated medication to my child. I further acknowledge by signing this form that the school district or its personnel are under no obligation to render assistance in administering medication and do hereby release all Board designated school employees and the Board of Education from any harmness from any and all liability for damages or injury resulting directly or indirectly from this authorization.

I have read and understand the policy for administration of medication.

Name of Student ____ School ________________________________

Parent Signature ____ Date _________________________________