



Roseville Area Schools

Dispensation of Medication

This procedure was developed to comply with School Board Policy JHCD, Dispensation of Medication (528P), and state mandates. It is designed to protect students, parents/guardians, and school personnel.

For the protection of students:

- All medications (with some exceptions) will be stored in the school health office.
- Medications dispensed in other programs and outside the normal school day should be stored in a secure location in that program area.
- If there are concerns about a prescription or nonprescription medication, the licensed school nurse will contact the healthcare provider and/or request a healthcare provider's order for an over-the-counter medication.
- A new medication permission form is required each and every school year.

Procedure

1. Medication prescribed for more than two (2) weeks and which must be taken at school must have this permission form signed by a healthcare provider and the parent/guardian.
2. Medication prescribed for less than two (2) weeks requires written permission from the parent/guardian only.
3. Over-the-counter medication should have this permission form signed by the parent/guardian.
4. All medications should be in original containers labeled with the following:
 - a) Student's Name, b) Medication Name, c) Dose, d) Time of Day to Take Medication, e) Healthcare Provider's Name

Authorization for Giving Medication at School

Student's Name: _____

Birth Date: _____

Grade: _____

School Year: _____

Diagnosis/ICD10	Medication	Dosage	Time	Discontinuation Date
				<input type="checkbox"/> End of Year <input type="checkbox"/> Other (specify):
				<input type="checkbox"/> End of Year <input type="checkbox"/> Other (specify):
				<input type="checkbox"/> End of Year <input type="checkbox"/> Other (specify):

Print Name of Healthcare Provider

Clinic Name

Signature of Healthcare Provider

Date

Clinic Phone Number/Fax Number

I hereby authorize school personnel to give the above medication and contact the healthcare provider with questions:

Signature of Parent/Guardian

Date

Cell/Home Phone Number

Work Phone Number

Send medication home with student at the end of the school year.

OR

Parent will pick up medication from school at the end of the school year.

HEALTH SERVICE ADMINISTRATION OF MEDICATION RECORD (K-8 SCHOOLS W/TRADITIONAL SCHOOL YEAR)

Student: _____
 Grade: _____ Teacher: _____
 Daily PRN Short Term
 Route: Oral Inhaled Topical Other
 Special Instructions: _____
 School Year: 2025-2026

Parent Signature Received
 HCP's Order/ Signature Received
 Medication: _____
 Dosage: _____
 Time: _____
 Date Started: _____
 Date Completed: _____

DAY	SEPT	OCT	NOV	DEC	JAN	FEB	MAR	APR	MAY	JUNE	ADMINISTRATION CHANGE	
1											Dosage:	
2											Time:	
3											Start Date:	
4											Completed	
5											Dosage:	
6											Time:	
7											Start Date:	
8											Completed	
9											Dosage:	
10											Time:	
11											Start Date:	
12											Completed	
13											Dosage:	
14											Time:	
15											Start Date:	
16											Completed	
17											Dosage:	
18											Time:	
19											Start Date:	
20											Completed	
21											School Nurse Signature	Initials
22												
23											School Nurse Signature	Initials
24												
25											Health Asst. Signature	Initials
26												
27											Health Asst. Signature	Initials
28												
29											Health Asst. Signature	Initials
30												
31												