Destiny Christian Academy

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Non-Prescriptive Over the Counter (OTC) and Prescription (Rx) Medical Contract

This form must be completed each school year for each medication.

STUDENT: _____ GRADE: _____ TEACHER:

_____ RELEASE FOR THE ADMINISTRATION OF MEDICATION TO STUDENT:

School personnel will cooperate with parents when a physician prescribes medication or a non-prescriptive OTC medication to be taken during school hours and is required for the student's health. However, the primary responsibility for the student taking medication at school rests entirely with the student and the student's parents. Students in 6th through 12th grade need to be responsible to come to the office during the time their medication is due. School personnel may assist the student in taking medication provided that the parent has complied with the school's requirements. Medication can only be given between 8:00am & 3:00pm, emergencies excepted.

ALL MEDICATION MUST BE IN THE ORIGINAL CONTAINER, NOT EXPIRED AND CORRECTLY PRESCRIBED (with pharmacy label) FOR THE INDICATED STUDENT ONLY. ALL MEDICATION MUST BE KEPT IN THE FIRST AID ROOM UNLESS THE STUDENT HAS A SELF ADMINISTRATION CONTRACT* ON FILE IN THE OFFICE (6th through 12th grade students only). THIS FORM IS GOOD FOR ONE MEDICATION AND FOR ONE STUDENT. Please submit additional forms for each medication, and each student. (*6th through 12th grade students only may be allowed to carry certain emergency medications with them, but only after parent, physician, and school office approval.)

☐ LONG TERM (longer than two weeks) MEDICATION: Medication that must be given for longer than two weeks must be accompanied by this Medical Contract. If it is a prescribed medication the form must be signed by the prescribing physician; or a written statement from the prescribing physician indicating the student's name, date, medication, dose, route, reason, and time(s) for which the medication is to be given. If the medication is considered OTC, a physician's signature is not required.

☐ SHORT TERM (1-14 days) PRESCRIPTION MEDICATION: Medication that must be given for less than two weeks must be accompanied by this medication release form; A physician's signature is not needed.

☐ *SELF-ADMINISTRATION OF MEDICATION: This is available to 6th through 12th grade students only. DCA recognizes that the health needs of the child named in this form may require the use of certain unscheduled rescue medications (i.e. insulin, epinephrine, inhalers). To accommodate that need, DCA will allow the child to self-administer the necessary medication upon request by the student, parent, and physician provided that the student has demonstrated the ability to carry and use the medication in a responsible, appropriate and safe manner. The medication must be labeled and in the original container with a back-up supply in the school health office. The MEDICATION SELF-ADMINISTRATION CONTRACT within this form must be completed for authorization to be granted.

☐ OVER THE COUNTER MEDICATION: OTC medication will only be given if the DCA Medical Contract is filled out completely and signed by the parent/guardian. NO EXCEPTIONS. A physician's signature is not needed.

NOTE: There is no school nurse at DCA, therefore, all medications should be administered at home whenever possible.

- I, the undersigned, request that medicine be administered to my child named on this document by a designated member of the school staff in accordance with instructions outlined on this document.
- I agree as soon as my child no longer needs to take this medication, I will personally retrieve the medication from the school office.
- School personnel have my permission to communicate with my child's physician and may counsel the physician regarding the possible effects of the medication on my child.
- In agreeing to have the school administer my child's medication, I voluntarily agree to release, discharge, and hold harmless DCA and its officers, agents, and employees for any and all claims of liability arising out of their negligence, recklessness or any other act of omission which causes my child's illness, injury, death, and damages of any nature in any way connected with the administration of my child's medication.
- I understand that the major responsibility for a student taking medication rests with the student and his/her parents/guardians, and that I am required to personally bring the medication to the school office.

_____ _____ _____

PARENT/GUARDIAN SIGNATURE DATE DAYTIME PHONE

MEDICATION: _____

DOSE: _____ TIME: _____ AM _____ PM_____

ONLY AS NEEDED EVERY _____ HOURS ROUTE: ☐ ORAL ☐ INHALE ☐ EYE (R L) ☐ EAR (R L) ☐

OTHER _____

REASON FOR MEDS: _____ SIDE EFFECTS: _____

GIVE MEDICATION UNTIL:_____ (date) OR UNTIL NOTIFIED SPECIAL

INSTRUCTIONS: _____

PHYSICIAN'S NAME (Please print): _____ PHONE _____

PHYSICIAN'S SIGNATURE _____ DATE_____

MEDICATION SELF-ADMINISTRATION - STUDENT, PARENT, PHYSICIAN CONTRACT

Rescue medications for 6th through 12th grade students only

- Students have demonstrated to the physician and parent/guardian correct use of the medication.
- Students agree never to share the medication with another person.
- Students agree to go to the school office immediately if there is not marked improvement after taking the medication. NOTE: If the medication is for severe allergic reactions, the student will seek additional medical attention immediately following administration of medication.
- We, the parents/guardians of the student named on this form, agree to assume all responsibility for the above-mentioned medication when it is brought on campus by the student.

Student Signature: _____ Date: _____

Parent/Guardian Signature: _____ Date: _____

Physician Signature: _____ Date: _____