



**DEPARTMENT OF DEFENSE  
EDUCATION ACTIVITY  
GEORGIA/ALABAMA DISTRICT**

Maxwell AFB Elementary/Middle School  
800 Magnolia Blvd  
Maxwell AFB, AL 36112  
334-953-7804  
334-953-4339

**H.3.1**

**Office of the School Nurse**

**DATE:** \_\_\_\_\_

**MEMORANDUM for:** Parents/Sponsor of \_\_\_\_\_

**SUBJECT:** Student Use of Medication During the School Day

The school nurse accommodates parent requests for medication (including prescription, nonprescription, and over-the-counter) to be administered during the school day. According to DoDEA Health Service Guide, DS Manual 2942.0, school personnel may administer medications when certain criteria are met.

In order for school personnel to administer medications during school hours, the attached form **MUST** be provided to the school signed by the **parent** and a **physician**.

The medication will be in the original container, **properly labeled by the pharmacy or physician**. The label should indicate the name of the student and the physician, the medication, dosage, and frequency. The date of the prescription must be a current date. All medications will remain at the school for the duration of the prescription. Any changes in the medication, dosage, or frequency will necessitate **a new form and a new, labeled container**.

Medications for acute illness (such as bacterial infections) are usually prescribed for administration three times a day and may be administered by the parent before school, after school, and before bedtime.

Please call the School Nurse at 953-7804 ext 1015 if you have any further concerns.



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H.3.2

**Department of Defense Education Activity  
Office of the School Nurse**

**To be completed by physician**

**Name of Student:** \_\_\_\_\_

**Diagnosis/Indication for Medication Administration:** \_\_\_\_\_

**Medication:** \_\_\_\_\_ **Dosage:** \_\_\_\_\_

**Time:** \_\_\_\_\_ **Route:** \_\_\_\_\_

**Duration:** \_\_\_\_\_

**Possible Side Effects:** \_\_\_\_\_

**Precautions/Restrictions:** \_\_\_\_\_

**Other Medications Taken:** \_\_\_\_\_

\_\_\_\_\_  
**Signature of Physician**

\_\_\_\_\_  
**Date**

**Clinic:** \_\_\_\_\_ **Phone:** \_\_\_\_\_

**To be completed by parent:**

I hereby give my permission for \_\_\_\_\_ to receive, from the school nurse and/or other trained school personnel, the above prescription at school as ordered. I understand that it is my responsibility to furnish the school with this medication. I give permission for the school nurse and health care providers at the medical treatment facility to exchange information about my child, the diagnosis for which this medication is prescribed, and my child's response to the medication.

\_\_\_\_\_  
**Signature of Parent/Guardian**

\_\_\_\_\_  
**Date**

Parent daytime phone number #1 \_\_\_\_\_, #2 \_\_\_\_\_,  
#3 \_\_\_\_\_

Parent e-mail address \_\_\_\_\_

**NOTE: The prescription medication must be brought to school in the original container, properly labeled by the pharmacy or physician, stating the name of the student, the medication, the dosage, and current date. The medication will remain at school for the duration of the prescription.**

**PRIVACY ACT STATEMENT**

AUTHORITY: 44 USC 3101. PRINCIPAL PURPOSES: (1) To provide necessary information to authorized individuals to assist them in their administering of medications to your child in accordance with your instructions and the instructions of your child's physician; (2) To provide written assurance to said authorized individuals that they will not be held responsible for any harm or injury suffered as a result of the administering of medication in accordance with your instructions and the instructions of your child's physician. ROUTINE USES: This form will be included in your child's school health record and will not be released outside DOD channels. DISCLOSURE: Voluntary. The information requested on this form is needed to insure the safe administering of medication to your child. Failure to provide the information may constitute grounds for refusal to provide the service requested by you.

NAME OF CHILD

BIRTH DATE

NAME OF SCHOOL

We, the parents of \_\_\_\_\_, wish to advise you that he/she is under the care of Dr. \_\_\_\_\_ for \_\_\_\_\_ and that the physician has furnished medications together with written instructions for administering the medications to alleviate this condition. The medication(s), physician's instructions, and times for administering the medication(s) are as follows:

**PHYSICIAN'S INSTRUCTIONS TO SCHOOL PERSONNEL**

Due to the nature of the medication(s) and/or the child's condition(s), it is necessary that the medication(s) listed below be administered during school hours.

Medication(s)

Physician's Instructions

Hour(s) For Administering

Anticipated number of days the medication(s) must be given at school (\_\_\_\_\_)

PHYSICIAN'S SIGNATURE

PHONE

DATE

We are delivering to you the medication(s) and the physician's written instructions and request this medication be given to our child in accordance with the above instructions. We fully understand that you are under no obligation whatsoever to administer the medication but will only be doing so as our agent acting in our behalf specifically and solely for this purpose.

We agree to hold you, the school, its offices, agents, and employees harmless in administering the medication(s) pursuant to the physician's written instructions and our instructions as to the times for administering the medication(s). We further agree to notify you promptly when it is no longer necessary to administer this medication.

PARENT'S SIGNATURE

HOME PHONE

DUTY PHONE

HOME ADDRESS