

# Destiny School

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## Medication Policy

If a student must take medicine during school hours, a parent or guardian will need to make arrangements with the school nurse. Because of the responsibility placed upon the staff for giving medication, we ask that you comply with the following guidelines.

1. Parent/Guardian must fill out a permission form requesting School Nurse or Destiny Staff to administer medications. Permission forms are available from the Nurse's office.
2. Medications must be brought to school by a parent or other adult. Students are not allowed to carry medications to or from school.
3. Medications must be kept in its pharmacy labeled container with the student's name on it. Medication brought to school in baggies or foil will be destroyed. If medication needs to be split them before they are brought to school. The school is not equipped no authorized to split tablets.
4. Non-prescriptions medication will be dispensed by the School Nurse or Destiny Staff to students who have written permission from a parent or guardian to receive medication at school. As needed, for a maximum of 2 consecutive days. A doctor's order must be submitted to the school health office for administration beyond this 2-day period.
5. DO NOT SEND any medication necessary for pain management that contains a narcotic, such as Tylenol 3. This will NOT be administered during school hours, regardless of a current prescription.
6. Parents/Guardians are responsible for picking up any remaining medication of the last day of school. Any medications not picked up will be discarded.

I HAVE READ THIS MEDICATION POLICY AND AGREE TO ADHERE TO THE ABOVE GUIDELINES.

Parent/Guardian \_\_\_\_\_ Date \_\_\_\_\_

Child's Name \_\_\_\_\_ Grade \_\_\_\_\_

Home Phone \_\_\_\_\_ Work Phone \_\_\_\_\_

Physician Name \_\_\_\_\_

Hospital (Preferred) \_\_\_\_\_

Destiny School  
Medication Use Form  
School Year \_\_\_\_\_

Students Name \_\_\_\_\_ Grade \_\_\_\_\_  
Date of Birth \_\_\_\_\_

I, \_\_\_\_\_ authorize the staff of Destiny School to  
Parent/Guardian  
dispense and or apply the medication or treatments listed below. I agree to release Destiny School and all Staff from any responsibility as a result of a problem that may arise from the administration of medications or treatments.

**MEDICATION WILL NOT BE ADMINITSTERED WITHOUT A PARENT OR GUARDIAN SIGNATURE ON THIS  
CONSENT FORM**

- \_\_\_\_\_ Ibuprofen
- \_\_\_\_\_ Tylenol (500 mg caplets)
- \_\_\_\_\_ Jr. Strength Tylenol/Jr. Ibuprofen
- \_\_\_\_\_ Pepto Bismol
- \_\_\_\_\_ tums Smoothies (for stomach ache)
- \_\_\_\_\_ Bactine (for cleaning wounds)
- \_\_\_\_\_ Cold or Hot Packs
- \_\_\_\_\_ Muscle Spray (for strains/sprains)
- \_\_\_\_\_ Triple Antibiotic Ointment
- \_\_\_\_\_ Band-Aids
- \_\_\_\_\_ Benadryl cooling gel (for itching or bites)
- \_\_\_\_\_ Children's Benadryl tablets
- \_\_\_\_\_ Children's cough syrup/cough drops
- \_\_\_\_\_ Vapor Rub (for nasal congestion)
- \_\_\_\_\_ Orajel (for minor toothaches)

***If your child needs allergy medication (other than prescribed) it must be provided by Parent/Guardian.***

Please specify if your child has any allergic reactions to any type or medication or dressing (i.e. bandages, tape, etc.)

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Please specify if you child has any illnesses that the school needs to be aware of:

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\_\_\_\_\_  
Parent/Guardian Signature

\_\_\_\_\_  
Date