

**CACHE COUNTY SCHOOL DISTRICT MEDICATION STORAGE FORM
THIS FORM IS ONLY FOR MEDICATION THAT IS ADMINISTERED AT SCHOOL
BY NON-DISTRICT PERSONNEL**



Student
Picture

Nursing & Health Services
Phone 435-752-3925
Fax 435-792-7796

STUDENT INFORMATION			Grade:
Student:	School:	SY: 22-23	DOB:
Parent:	Phone:	Email:	
Prescriber Name:	Phone:	Fax:	
School Nurse:	Phone:	Fax:	

Principal and School Nurse acknowledge that the medication below is being stored at the school to be administered by non-district personnel.

School Nurse Signature: _____ **Date:** _____ **Principal Signature:** _____ **Date:** _____

Parent: To complete the above section, read and sign below.

As parent/guardian I request the medication(s) listed below be stored at school to be administered to my student by non-district personnel. I give my permission for Cache County School District to store the medication listed below.

- I UNDERSTAND:**
- Medication will not be administered by school employees.
 - Depending upon the type of medication it is the medication It will be stored in a designated locked cabinet or a secure location. This will be according to the State of Utah Medication Statues for public schools.
 - School personnel will gather the medication or unlock the medication upon non-employee arrival for administration.
 - Parent or guardian is responsible for maintaining necessary supplies, medications, and equipment.
 - All medication must be transported to and from the school by the parent/guardian.
 - Prescription medication must be in the current original pharmacy container/label, with the child's name, medication name, administration time, dosage, and health care provider's name.
 - The information contained in this order will be shared with school staff on a need-to-know basis.
 - Medication inventory will not be tracked by school personnel.
 - It is my responsibility to notify the school nurse of any change in my student's health status, care, or medication order.

Parent Signature: _____ **Date:** _____

MEDICATION BEING HOUSED AT SCHOOL

Name of Medication:	Dose:	Type of Medication:
Medication will be kept: <input type="checkbox"/> In the office <input type="checkbox"/> In the classroom <input type="checkbox"/> Other:		
Additional Instructions:		

MEDICATION CHECK-OUT

Medication Picked up: Parent Picked Up Expired Discarded as per school medication policy at the end of the school year

Parent Signature: _____ **Date:** _____