Tripoli Community School District

209 8th Ave. S.W. Tripoli, Iowa 50676-9662

TROY HELLER	KAREN NEUENDORF	TRACIE FETTE	SARAH FIGANBAUM	TONY SNEIDERMAN
Superintendent	**6-12 Principal**	**Business Manager/ Board Secretary**	**PK-5 Principal School Improvement Coord.**	**Activities Director**
319-882-4202	**319-882-4202**	**319-882-4201**	**319-882-4203**	**319-882-4204**
FAX # 319-882-3103	**FAX # 319-882-3103**	**FAX # 319-882-3103**	**FAX # 319-882-3649**	**FAX # 319-882-3103**

Section B: To be signed and completed by the attending physician and returned to the School to be kept on file.

Name of student to receive medication ______________________________
Name of medication ______________________________________

To comply with the requirements conferred to the D.P.I. in section 281.3 of the Code of Iowa and set up in the rules and regulations governing the administration of prescribed medication by the school personnel during school hours we must have the following information on file.

To comply with Division VII 12.29 (4)a, please supply the following information:

1. Frequency of administration of the above medication ________________
   ____

2. Amount of medication at each administration ____________________

3. Method of administering the medication _______________________

4. Description of anticipated reactions of the student to the medication
   ____
   ____
   ____
   ____

______________________ ______________________________
Date Signature of Attending Physician

____
Address

(Please return this form to parent or fax it to Tripoli Community School at 319-882-3103.)

MEDICATION

If you wish your child to receive any over the counter or prescription medication (non-aspirin, cough medicine) you need to send written permission to do so. This form will need to be completed. We cannot administer medication of any kind without written permission.

Medication Policy

Section A: Signed by parent and returned to Tripoli Community School office.

Name of student to receive medication ______________________________

Name of medication ____

I am requesting that the above student receive medication, which because of the time of day necessitates that school personnel administer the medication. I agree that the principal will assign the person responsible for the administration of the medication. I will be responsible for having the prescription refilled when needed.

To conform to the requirements conferred by Section 281:3 of the Code of Iowa, I will

1) Supply the school with the physician's directions on the form provided by the school and signed by the physician which specifies frequency, amount and method administration of the medication as required by law in Division VII 12:29 (4)a of the rules and regulations of Special Education.
2) Furnish the school, on a form provided by the school, the physician's description of the anticipated reaction of the child to the medication as required by law in Division VII 12:29 (4)a of the rules and regulations of Special Education. This description must be signed by the physician to meet state requirements.
3) Supply the school with the original prescription container which will be labeled with:
    a. Name of Pupil
    b. Name of Medication
    c. Directions for use
    d. Name of physician
    e. Name and address of Pharmacy
    f. Date of Prescription

   as required by law in Division VII, 12:24 (4)c of the rules and regulations of Special Education.

I agree to fulfill the above requirements so my request for the administration of medication by school personnel during school hours to the above named student may be fulfilled and I give my permission for authorized school personnel to administer the medication as directed by the attending physician.

If students carry and/or take prescription or non-prescription drugs themselves, Tripoli Community Schools will not assume liability for any consequence.

______________________ ______________________________

Date Signature of Parent or Legal Guardian