H-3-2	**DEPARTMENT OF DEFENSE EDUCATION ACTIVITY** **MEDICATION DURING SCHOOL DAY**	

PRIVACY ACT STATEMENT

AUTHORITY: 10 U.S.C. section. 2164 (Department of Defense Domestic Dependent Elementary and Secondary Schools) and 20 U.S.C. sections 921-932 (Defense dependents' education system).

PRINCIPAL PURPOSE: Obtain health related information about a student enrolling or enrolled in Department of Defense Education Activity (DoDEA) schools and programs to protect and enhance student health and promote a safe school environment. Determine services to be provided for a student in an equal opportunity to participate in public education.

ROUTINE USES: DoDEA may release information without prior consent within the Department of Defense (DoD) when needed to perform an official DoD duty, in accordance with 5 U.S.C. section 552a (b) (1). DoDEA also may release information outside the DoD, in accordance with 5 U.S.C. section 552a (b) (2-12), and the "Blanket Routine Uses," published at http://dpcld.defense.gov/Privacy/SORNsIndex/BlanketRoutineUses.aspx. Examples of release may include for valid medical, law enforcement or security purposes, or for use in litigation involving the DoD.

DISCLOSURE: Voluntary. However, failure to provide the requested information may result in the delay or denial of student services.

Medication During School Day

PCM/ Sponsor/Parent/Guardian Signatures

_____ School *(enter name of school)*

To be completed by Physician/Primary Care Manager

Name of Student _____ DOB: _____ Grade: ____

Diagnosis and indication for medication administration _____

Medication	Dosage	Time	Route	Duration	Possible side effects

Precautions/Restrictions: _____

_____ _____

Physician/Primary Care Manager (PCM) Signature & Stamp Clinic Phone number

To be completed by Sponsor/Parent/Guardian. Please return completed form to the school nurse.

I hereby give permission for my dependent (student's name) _____ to receive, from the school nurses 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. It is also my responsibility to pick up the medication at the end of the school year or when the medication is no longer to be administered to my dependent. I understand that medications left in the School Health Office after the current school year will be destroyed.

I give permission for the school nurse and my dependent's health care providers to exchange information about the diagnosis for which this medication is prescribed and my dependent's response to the medication. This permission is valid for this current school year, only. I understand that it is my responsibility to inform the school of changes in my dependent's health status or contact information as originally provided to the school.

NOTE:

- Prescription medications must be brought to school in the original container, labeled by the pharmacy, stating the name of the student, the medication, reason for administration, dosage, route, time of administration and the date issued.
- Prescribed medications purchased as an over-the-counter medication and not subject to a pharmacy label, must be brought to school in the original *unopened* container labeled by the sponsor/parent/guardian with the student's name, date of purchase and reason for administration.
- All medications will remain at school for the duration of the prescription.

_____ _____

Signature of Sponsor/Parent/Guardian Date

To be completed by Nurse

Date Medication received: _____ Amount of medication received: _____ Expiration date of medication: _____

Nurse's Notes: _____

Signature of School Nurse: _____