MEDICATION CHECK-IN FORM **Fargo Public Schools**

AF 6720-I

NOTE: To be completed by an eligible school medication provider prior to accepting medication from parent/guardian or authorizing a student to self-administer. If the answer to any question is "no," the district may defer the medication request until the parent/guardian provides the required information.

Medication was hand delivered by parent/guardian: ☐ Yes ☐ No *If no, collect medication, store as directed, and contact parent/guardian to come to school as soon as possible to verify medication request.*

- Parent submitted **fully** completed authorization form: ☐ Yes ☐ No
- If request is to provide/authorize over-the-counter medication in manner other than recommended by manufacturer, authorization from healthcare provider is included: ☐Yes ☐ No ☐ N/A
- Includes healthcare provider's signature for prescription medication: ☐ Yes ☐ No ☐N/A

Name of medication:________________________________ ☐ Prescription ☐ Over-the-counter

Name of student:____________________________________ Date of Birth:_________________

Who is requested to provide medication? ☐ School personnel ☐ Student under supervision ☐ Student without supervision ☐ Check here if request is for student to carry the medication.

Route by which medication must be given: ☐ Mouth ☐ Eyes ☐ Ear ☐ Nose ☐ Topical (e.g., skin ointment) ☐ Other:____

NOTE: If other, check with school administrator to determine if school is obligated/willing and has qualified personnel to provide medication. This provision is not applicable if request is for student to self-administer.

Medication expiration date:____________Was this listed on the medication container? ☐ Yes ☐ No

Amount of medication in container:_____________________________

For prescription medication:	**Yes**	**No**		**Yes**	**No**
Medication in original pharmacy container			Container lists storage instructions		
Container lists amount of medication dispensed			Container is labeled with student's name and date of birth		
Container lists dosage			Container lists pharmacy name and phone number		
Container lists administration instructions					
For over- the-counter medication:	**Yes**	**No**		**Yes**	**No**
Medication in original manufacturer's container			Container lists storage instructions		
If container is unsealed, it is labeled with amount of medication contained in it			Container lists medication's name		
Container lists recommended dosage			Container lists ingredients		
Container lists administration instructions			Container is labeled with student's name and date of birth		
If dispensing equipment is required:	**Yes**	**No**		**Yes**	**No**
Did parent/guardian provide necessary equipment?			Is the dispensing equipment clean and in good working order?		
Is the equipment labeled with the student's name and date of birth?					
List any storage instructions for dispensing equipment:					

Name of School Medication Provider (Printed)	**Signature of School Medication Provider**	**Date**