STRIDE ACADEMY

Medication Administration in School

* One Medication per Form

The Parent/Guardian of ______________________________ *ask that STRIDE Academy staff give the*
(Child's Name)

following medication ______________________________ *at* ____________________
(Name of Medicine and Dosage) *(Time(s) of Day)*

to my child, according to the Health Care Provider's signed instructions on the lower part of this form.

- The School agrees to administer medication prescribed by a licensed health care provider.
- It is the parent/guardian's responsibility to furnish the medication and proper measuring device(s).
- The parent agrees to pick up expired or unused medication within one week of notification by staff.
- ***Prescription*** medications must come in a labeled container by Pharmacist/Physician with: child's name, name of medicine, time medicine is to be given, dosage, date medicine is to be stopped (if appropriate), and licensed health care provider's name. Pharmacy name and phone number must also be included on label.
- ***Over the Counter*** medications must be labeled with child's name and packaged in the original container Dosage must match the signed licensed health care provider authorization .

By signing this document, I give permission for my child's health care provider to share information about the administration of this medication with the School Nurse or delegated school staff to administer medication.

____________________ ____________________ ____________
Parent/Guardian's Name *Parent/Guardian Signature* *Date*

____________________ ____________________ ____________
Work Phone *Home Phone* *Cell Phone (if applicable)*

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Health Care Provider Authorization to Administer Medication in School

Child's Name: ______________________________ Birth Date: ____________________

Medication: ______________________________ Dosage: ____________ Route: ____________

To be given at the following time(s) in School: ______________________________

Special Instructions: N/A or ______________________________

Purpose of Medication: ______________________________

Side effects which need reporting: N/A or List: ______________________________

Starting Date: ____________________ Ending Date: N/A or: ____________________

______________________________ ____________________
Signature of Health Care Provider with Prescriptive Authority *Name of Medical Facility*

______________________________ ____________________
Phone Number *Date*

Please ask the Pharmacist for a separate medicine container to keep at the School

Forms or Physician orders may be faxed to 320-217-6318 Attn: Health Services

Thank you!