

**PRESCRIPTION MEDICATION FORM**

**THE SCHOOL ASSUMES NO RESPONSIBILITY FOR NON-MEDICALLY PRESCRIBED  
 MEDICATION OR MEDICATION ADMINISTERED BY THE PUPIL THEMSELVES.**

**NO MEDICATION WILL BE ADMINISTERED UNLESS:**

1. The Prescription Medication Form is completed and **signed** by a licensed prescriber.
2. The parent/guardian and the school nurse/designee reviewed and **signed** the Prescription Medication Form.
3. The medication listed on the Prescription Medication Form is presented by the parent/guardian to the school nurse/designee in its original container with the original pharmacy label.

**MEDICATION CANNOT BE TRANSPORTED ON THE SCHOOL BUS OR BY ANY CHILD.  
 PARENTS/GUARDIANS MUST BRING IN MEDICATION TO THE SCHOOL NURSE.**

**TO BE COMPLETED BY A LICENSED PRESCRIBER**

Name of Student: \_\_\_\_\_ Date of Birth: \_\_\_\_ / \_\_\_\_ / \_\_\_\_ Grade: \_\_\_\_\_

School: \_\_\_\_\_

Diagnosis: \_\_\_\_\_

Medication/Treatment Required: \_\_\_\_\_

Dosage: \_\_\_\_\_ Route: \_\_\_\_\_ Time/Schedule: \_\_\_\_\_

Special instructions, precautions, side effects: \_\_\_\_\_

*I have examined the above child and determined that the above medication is medically necessary during school hours.*

Physician/Nurse Practitioner Name (Please Print): \_\_\_\_\_

Address: \_\_\_\_\_

Telephone: \_\_\_\_\_ Fax: \_\_\_\_\_

Licensed Prescriber Signature: \_\_\_\_\_ Date: \_\_\_\_ / \_\_\_\_ / \_\_\_\_

**Note: This order is valid for the school year in which it is signed and must be replaced each school year and/or with any changes. Any changes in the written order require a corresponding change in the prescription label.**

**STATEMENT OF PARENT/GUARDIAN**




**To Be Completed By Parent/Guardian:**





I am unable to personally administer the above medication to my child and no other family or relative is able to do so. I request, and hereby authorize, the school to administer the above medication as prescribed. I consent to the exchange of information between the Licensed Prescriber with the school nurse regarding the medication and treatment.

Signature of Parent/Guardian: \_\_\_\_\_ Date: \_\_\_\_ / \_\_\_\_ / \_\_\_\_

Home Telephone: \_\_\_\_\_ Work Telephone: \_\_\_\_\_ Cell Phone: \_\_\_\_\_

School Nurse/Designee Signature: \_\_\_\_\_ Date: \_\_\_\_ / \_\_\_\_ / \_\_\_\_

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