Park Rapids Schools Health Service Medication Form

Prescription Medication

Parents of students requesting prescription medication to be given to their child during school hours by school staff are required to provide the school with the following information. All medication MUST be sent in the original container or pharmacy labeled bottle. A Licensed School Nurse will designate persons giving the medication.

Student Name: ________________________ Date of Birth: ________ Grade: ____
Parent Name: _________________________ Phone: __________________________

Physician Order

I have prescribed the following medication for this child and request it is given during the designated school hours.

Medication: ___________________________________ Dosage/Time: ______________________

For the treatment of: ____

Special Instructions: ____

Possible Side Effects: (optional) ____

Physician Signature: _______________________________________ Date: _____________

Physicians Name: ________________________ Phone: _______________ Fax: ______________

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PARENT REQUEST FOR ADMINISTRATION OF MEDICATION

______ I request this prescription medication to be given as prescribed by the doctor

______ I request this non-prescription medication to be given to my child

Name of Medication: ____

Dosage and Time: ____

Treatment of: ____

How long to be given: ____

Parent/Guardian Signature: ____________________________________ Date: ______________

PARK RAPIDS SCHOOL DISTRICT HEALTH SERVICE MEDICATION FLOW SHEET

Student Name: ______________________________ Date of Birth: ____________ Grade: ______

Medication: ________________________________ Dosage/Time: ___________________________

Date Started: _______________________________ Date Discontinued: ______________________

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Staff Initials & Name: ________________/________________/________________/_____________