



School Health Services
Prescription Medication Administered at School

Attach Student Picture If available

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

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

Class/Grade: \_\_\_\_\_

Student Name: \_\_\_\_\_ D.O.B.: \_\_\_\_\_

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

To Be Completed by Physician/Healthcare Provider:

Name of medication: \_\_\_\_\_ Dose: \_\_\_\_\_

Time to be given: \_\_\_\_\_ (during school hours)

Reason for medication: \_\_\_\_\_

Form of medication: \_\_\_ Tablet \_\_\_ Liquid \_\_\_ Inhaler \_\_\_ Nebulizer \_\_\_ Other

Start Date: \_\_\_\_\_ Stop Date: \_\_\_\_\_

Special Instructions: \_\_\_\_\_

Potential adverse reactions to be reported: \_\_\_\_\_

Physician/Healthcare Signature: \_\_\_\_\_ Date: \_\_\_\_\_

Physician/Healthcare Provider Name: \_\_\_\_\_ Print Name

Phone: \_\_\_\_\_ Fax: \_\_\_\_\_

Parent/Guardian: I give permission for my child to receive this medication at school according to the school district policy and as instructed by my healthcare provider.

I agree and am responsible to:

- Medication to be delivered to school by parent/guardian, not expired, in its original container and labeled by a pharmacist or healthcare provider
• Tell the school as soon as possible if there is a change in the use of my child's medicine
• Tell the school if my child gets a new healthcare provider
• Have my healthcare provider complete a new medicine form for my child if the medicine or dose changes.

I agree for child's healthcare provider to talk with the school or any school staff person about this medicine. No other part of my child's medical health will be discussed.

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

Parent/Guardian Phone: \_\_\_\_\_ Emergency Alternate Phone: \_\_\_\_\_

Clinic Use Only: Date form received \_\_\_\_\_ Date medication received: \_\_\_\_\_ Form Complete (Y or N) \_\_\_\_\_
Notes: \_\_\_\_\_ Date Form complete: \_\_\_\_\_