LEETONIA EXEMPTED VILLAGE SCHOOLS

STUDENT MEDICATION FORM

TO BE COMPLETED BY LICENSED PRESCRIBER:

Student Name ____________________ Birth Date ____________

Address ____________________ Phone ____________

Diagnosis ____________________

Name of Medication: Dosage: Time: Route: ____________________

____

Length of time medication shall be administered:

From: ____________ To: ____________

Possible Reactions ____________________

Special Instructions: (Storage, Special Techniques) ____________________

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LICENSED PRESCRIBER SIGNATURE ____________________ Date ____________

Licensed Prescriber (Typed or Printed) ____________________

Licensed Prescriber Address ____________________

Licensed Prescriber Phone ____________________

TO BE COMPLETED BY THE PARENT/GUARDIAN:

I hereby authorize and request designated personnel of the school to administer the above named medication as instructed by the Licensed Prescriber and absolve the school and school personnel from any responsibility which might be associated with the administration of such medication.

I/We grant permission for the Licensed Prescriber and school nurse to communicate in regards to this medication.

I/We also agree to:

1. Deliver the medication to the school in an original prescription bottle.
2. Notify the school if we change Licensed Prescribers.
3. Notify the school if the medication or dosage is changed or eliminated.

PARENT/GUARDIAN SIGNATURE ____________________ Date ____________

Address ____________________ Phone ____________

TO BE COMPLETED BY SCHOOL PERSONNEL:

I hereby acknowledge reading this request to administer medication and understand its content as well as the content of the Board Policy.

SCHOOL NURSE SIGNATURE ____________________

Person(s) authorized to administer medication

____________________ ____________________

____________________ ____________________

Date Medication received ____________

Updated May 2005