

2026-2027 School Year

PRESCRIPTION & EMERGENCY MEDICATION IN SCHOOL FORM

Student Name: _____ Birthdate: _____ Grade: _____

Parent/Guardian Name(s): _____

Phone Number(s): _____

Section 1. Administrative Statement

School personnel may administer medication during school hours when authorized by a licensed healthcare provider and a parent/guardian. Whenever possible, medications should be administered outside of school hours. Medication will be administered by the school nurse or trained designated staff in accordance with the completed authorization form, applicable care plan, school procedures, and applicable law.

Section 2. Parent/Guardian Consent & Acknowledgment

Parent/Guardian: Please read carefully and sign below.

- **Healthcare Provider Authorization:** A licensed healthcare provider's signature is required for all prescription and student-specific emergency medications administered at school, except as otherwise permitted by applicable law, emergency protocols, or standing orders. Medication will not be administered without the required completed and signed documentation on file.
- **Medication Requirements:** All prescription medications must be in their original pharmacy-labeled containers. Medication labels must include the student's name, medication name, dosage, route of administration, administration schedule, and prescribing provider. Medications will be administered per label instructions or as directed by a licensed healthcare provider.
- **Drop-Off & Pick-Up:** A parent/guardian or authorized adult designee must deliver and retrieve all medications. Medication may not be sent with the student, except when specifically authorized in writing for approved self-carry emergency medication.
- **School Nurse Availability:** The school nurse may not always be available. In the nurse's absence, a trained designated staff member may administer medication in accordance with school procedures and the completed authorization form.

Parent/Guardian Responsibilities: I understand and acknowledge the following:

- I will notify the school nurse of any changes to my child's condition, medication, dosage, administration schedule, or emergency care plan and provide updated forms as needed.
- School personnel may consult with the prescribing provider and/or pharmacist as needed regarding medication administration.

- For medications ordered “as needed,” my child should notify the school nurse or designated staff when medication is needed, when developmentally appropriate.
- If my child is approved to self-carry and/or self-administer emergency medication, my child must notify the school nurse or designated staff as soon as reasonably possible after use.
- I release the School and its employees, agents, and designated staff from liability related to adverse reactions or other outcomes resulting from medication administered in accordance with this completed authorization form, except as otherwise prohibited by law.

An additional care plan may be required for students with food allergies, anaphylaxis, asthma, diabetes, seizure disorders, or other medical conditions requiring emergency medication.

Parent/Guardian Signature: _____ Date: _____

Section 3. Physician Medication Instructions

(To be completed by the licensed healthcare provider. Complete one block per medication.)

Medication 1

Medication Name & Strength: _____ Diagnosis: _____

Dosage & Frequency: _____ Method of Administration: _____

Side Effects to Monitor: _____ Special Instructions: _____

Medication 2 (if applicable)

Medication Name & Strength: _____ Diagnosis: _____

Dosage & Frequency: _____ Method of Administration: _____

Side Effects to Monitor: _____ Special Instructions: _____

Medication 3 (if applicable)

Medication Name & Strength: _____ Diagnosis: _____

Dosage & Frequency: _____ Method of Administration: _____

Side Effects to Monitor: _____ Special Instructions: _____

Section 4. Physician Authorization

(To be completed by the licensed healthcare provider.)

My signature below **authorizes the orders above** to be carried out by the school nurse or trained designated school personnel. Authorization is valid for up to one school year.

Permission to Carry & Self-Administer Emergency Medication

Students may carry and/or self-administer emergency medication only when authorized in writing by both the licensed healthcare provider and parent/guardian and approved by the school.

Emergency medications may include, as applicable:

- Epinephrine auto-injector for severe allergic reactions/anaphylaxis
- Inhaler for asthma
- Insulin and/or glucagon for diabetes
- Other emergency medication specifically ordered by the licensed healthcare provider

Healthcare Provider: *(Check one.)*

- ☐ In my opinion, this student **IS** competent to safely carry and self-administer their emergency medication listed above.
- ☐ In my opinion, this student is **NOT** competent to safely carry and self-administer their emergency medication listed above.

Licensed Healthcare Provider Signature: _____ Date: _____

Phone: _____ Address: _____

Section 5. Parent/Guardian Permission to Carry & Self-Administer EMERGENCY Medication

(To be completed by the parent/guardian.)

Parent/Guardian: *(Check one.)*

- ☐ In agreement with my child's licensed healthcare provider, I **GIVE** permission for my child to carry and self-administer the emergency medication listed above.
- ☐ I do **NOT** give permission for my child to carry and self-administer emergency medication.

Parent/Guardian Signature: _____ Date: _____

Section 6. School Approval for Self-Carry/Self-Administration

(To be completed by the school.)

- ☐ Approved
- ☐ Not approved

School Nurse/Administrator Signature: _____ Date: _____