



Prescribed Medication for Administration by School Personnel

Student Name: _____ Campus: _____ Grade: _____

Student ID: _____ DOB: _____

Medication Administration Instructions (must align with information on bottle or doctors note):

Medication: _____ Dosage: _____

Start Date: _____ End Date: _____

Route of administration (circle): Tablet/Capsule Liquid
 Nebulizer Injection
 Inhaler * Other: _____

Time medication is to be given at school: _____

(If to be given at lunch, please be aware that the student's lunch may not be at noon. Please state "lunch" so that the time frame may be adjusted according to the student's lunch schedule)

Condition for which the medication is to be given: _____

Special Instructions: _____

Storage Requirements: Room Temp Refrigerate Other: _____

Prescribing Physician's Information:

Physician's Name (print): _____

Physician's Signature: _____

Physician's Address: _____

Physician's Phone: _____ Fax: _____

To be completed by parent/guardian:

I give permission for (student) _____ to receive the above medication at school according to standard school policy. The nurse/school administrator has my permission to inform my child's teacher(s) about this medication. The nurse/school administrator has my permission to speak with my child's physician as needed.

Signature: _____ Relationship: _____ Date: _____

Phone Number(s): _____

Parents/guardians are required to bring all medication to school in its original container with the correct labeling. All medication must be picked up by the parent/guardian from the school clinic when the medication is discontinued without using all of the medication or at the end of the school year. The school nurse will dispose of medication left in the clinic at the end of the school year.

* If inhaler is to be carried and administered by student, the Consent to Carry & Self Administer form will need to be completed, in addition to this form.