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: ____

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Physician/Healthcare Signature: ____ Date: _____________________

Physician/Healthcare Provider Name: ____
Print Name

Phone: ____ Fax: ____

<u>**Parent/Guardian:**</u> **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: _________________________

THIS FORM WILL EXPIRE AT THE END OF THE SCHOOL YEAR

Clinic Use Only: Date form received ______________ Date medication received: _____________ Form Complete (Y or N) ______

Notes:____Date Form complete: _____________