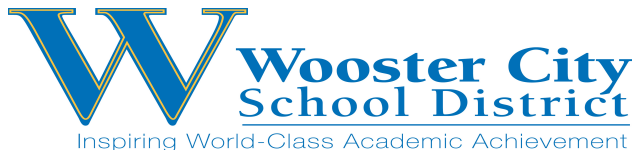




Prescription Medication Administered at School



School: _____

School Year: _____

Class/Grade: _____

Student Name: _____ D.O.B.: _____

Student Address: _____

To Be Completed by Doctor/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/Provider Signature: _____ Date: _____

Physician/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:

- Deliver my child's medicine to school 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