



## School Medication Administration Form 2023-2024

-ONE (1) MEDICATION PER FORM – REQUIRED FOR ALL (PRESCRIPTION & OVER THE COUNTER) MEDICATION

-Form is required to be completed each school year (and with changes)

-Medication must be submitted in original container / with a printed label from the pharmacy (if prescription) that matches below information

-Medication must be transported to/from school by an adult and locked in the Health Office (unless alternate plan is made with the health office)

Student Name: \_\_\_\_\_ Grade: \_\_\_\_\_ Birth Date: \_\_\_\_\_

### Prescriber Portion

Medication Name: \_\_\_\_\_ Concentration: \_\_\_\_\_

Dose: \_\_\_\_\_ Route: \_\_\_\_\_ Frequency: \_\_\_\_\_

Indication or instructions for “as needed” med: \_\_\_\_\_

Possible Side Effects: \_\_\_\_\_

For Emergency Medication- The student is capable, has been instructed in the proper use of this medication, and may self-carry / self-administer this medication: Yes  No  (Check one)

Date: \_\_\_\_\_ Prescriber Name: \_\_\_\_\_

Prescriber Signature: \_\_\_\_\_ Phone/Fax: \_\_\_\_\_

### Parent/Guardian Portion

*I request this medication be given as prescribed (above) including on field trips. I release school personnel from any liability in the administration of this medication and understand that I am responsible for communication with the healthcare provider who is ordering this medication. I understand that this medication will not be administered by a school nurse. I understand that this authorization will be effective and needs to be renewed each school year. I agree to provide medication in the unopened original container (for over the counter med) / with a printed label from the pharmacy (prescription med) and pick the medication up at the end of the school year. I will provide all necessary devices required to administer this medication, if needed (ie: nebulizer mask/tubing, syringes, pill crusher, medcup, etc). Information may be exchanged with staff working with my child, medical providers, and emergency personnel, if needed, to ensure the student's safety.*

For Emergency Medication- The student is capable, has been instructed in the proper use of this medication, and may self-carry / self-administer this medication: Yes  No  (Check one)

Date: \_\_\_\_\_ Parent/Guardian Name: \_\_\_\_\_

Parent/Guardian Signature: \_\_\_\_\_ Phone: \_\_\_\_\_