SCHOOL MEDICATION/PROCEDURE FORM

STUDENT INFORMATION: (to be filled out by Parent/Guardian)

Student's Name	Birthdate	School
Medication/Procedure	Dosage	Time/Frequency
School Year or Effective Dates	Student's Physician	
Reason for Medication/Procedure		

PHOTO ID
(optional)

Note: For prescription medication: Signed <u>Parent Consent</u> and signed <u>Physician's Order</u> required.
For non-prescription medication: Signed <u>Parent Consent</u> required.

<u>PHYSICIAN ORDER:</u> Complete for EACH PRESCRIPTION MEDICATION/PROCEDURE at school

The above medication procedure is to be administered during the school day in accordance with the above instructions.
Please contact me if the following symptoms occur:_____

_____

Additional information:_____

For Asthma inhalers ONLY - Student may carry inhaler in school YES NO

Date	Physician's Signature	Telephone Number

<u>PARENT CONSENT:</u> Complete for EACH MEDICATION/PROCEDURE at school (Please review your school's handbook for specific information regarding the medication policy.)

I request that this medication/procedure be administered at school.

Medication will be supplied in its original, updated, properly labeled container.

This order is in effect for this school year unless otherwise indicated.

I will notify the school in writing for any changes and obtain a new physicians order.

I authorize school personnel to exchange information verbally or in writing with my child's physician regarding this medication or the condition for which it is prescribed.

I release the school district and school personnel from any liability claims as a result of the administration of this medication or procedure as directed.

Date	Parent/Guardian Signature	Telephone Number

MEDICATION RECORD

Student's Name: _____Date of Birth:_____ Grade/Unit:_____
Medication/Dosage/Time:_____
Start Date: _____Stop Date: _____

Date	Time	Initials	Observations	Date	Time	Initials	Observations

To be filed in Student Health Folder When Medication is Discontinued

Nurses Use

Initials	Signature	Initials	Signature
_____	_____	_____	_____
_____	_____	_____	_____
_____	_____	_____	_____
_____	_____	_____	_____

For District Nurses Use