SCHOOL MEDICATION/PROCEDURE FORM

STUDENT INFORMATION:

Student's Name _____ Date of Birth _____ School _____

Medication/Procedure _____ Dosage & Route _____ Time/Frequency _____

School Year or Effective Dates _____ Student's Healthcare Provider _____

Reason for Medication/Procedure _____

PHOTO ID
(Optional)

NOTE: For prescription medication: Signed Parent/Guardian Consent and signed Healthcare Provider's Order required.
For non-prescription medication: Signed Parent/Guardian Consent required.

PARENT CONSENT: 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, 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 Healthcare Provider's order.

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

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

Date _____ Parent/Guardian's Signature _____ Telephone # _____

PROVIDER'S ORDER: Complete for EACH PRESCRIPTION/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 – Student may carry inhaler in school **YES** **NO**

For Epinephrine Auto Injectors – Student may carry injector in school **YES** **NO**

Date _____ Healthcare Provider's Signature _____ Telephone # _____

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)

Initials	Signature	Initials	Signature

(For District Nurse Use)