

# ADMINISTERING MEDICATION TO STUDENTS

*(Please return to your child's school)*

Student Name \_\_\_\_\_

Practitioner's Name \_\_\_\_\_

Date of Birth \_\_\_\_\_ Male \_\_\_\_\_ Female \_\_\_\_\_

Practitioner's Address \_\_\_\_\_

School \_\_\_\_\_

\_\_\_\_\_

Parent/Guardian \_\_\_\_\_

Practitioner's Phone \_\_\_\_\_

Home Phone \_\_\_\_\_ Work Phone \_\_\_\_\_

Practitioner's Fax \_\_\_\_\_

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To Parent/Guardian/Practitioner:

In accordance with state law, school personnel may give prescription medication to students only with complete directions from a practitioner and signed consent by the student's parent/guardian. School personnel may give non-prescription medication to students only with directions and signed consent from the student's parent/guardian. Medication must be supplied in the original container or packaging. For safety and liability reasons, medication received in any container or package other than the original will not be acceptable for staff administration. By signing this form, you release the Board of Education, its agents and employees from any and all liability which may result from taking this medication.

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If prescription medication is to be administered at school or during a school-sponsored activity, the following information must be completed by the student's practitioner and signed by both the parent/guardian and practitioner. If non-prescription medication is to be administered, the following information must be completed and signed by the student's parent/guardian.

Medication \_\_\_\_\_

Dosage \_\_\_\_\_

Frequency \_\_\_\_\_

Start Date \_\_\_\_\_

End Date \_\_\_\_\_

Form: \_\_\_\_\_ Tablet/Capsule \_\_\_\_\_ Liquid \_\_\_\_\_ Inhaler \_\_\_\_\_ Nebulizer \_\_\_\_\_ Injection

\_\_\_\_\_ For episodic emergency events only \_\_\_\_\_ Other \_\_\_\_\_

Time(s) to be given \_\_\_\_\_

Reason for this medication \_\_\_\_\_

If given on an "as needed" basis, please describe \_\_\_\_\_

Special instructions \_\_\_\_\_

Side effects (expected or predictable) \_\_\_\_\_

\*Emergency Medications (inhaler, glucagon, insulin, epipen) student to self-administer/carry \_\_\_\_\_ Yes \_\_\_\_\_ No

.....  
Parent/Guardian Signature: \_\_\_\_\_ Date: \_\_\_\_\_

*(Signature required for prescription and non-prescription medication)*

***As the authorizing physician, I am willing to accept direct communication from the person dispensing and administering the above medication.***

Practitioner's Signature: \_\_\_\_\_ Date: \_\_\_\_\_

*(Signature required for prescription medication only)*