# Medication Form

Date

Entering grade

**This form is to be completed by a physician and parent before any prescription medication can be administered in school.**

Name Male Female

last first middle

Medication Dosage Route

Frequency Time(s) to be given at school

*(Please note: Whenever possible, medication should be scheduled at times other than school hours)*

Possible side effects

Specific directions or information for

administration

Date

of

Order

Discontinuation

Date

Diagnosis\*

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Drug/Food

Allergies

Name of

Licensed

Prescriber\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Title

Signature of Licensed Prescriber Date

Address Phone

*\* if not in violation of confidentiality*

## **Parent**

Name of Parent/Guardian Relationship to student

List of additional medication taken at home

I give permission for my son/daughter to self-administer medication, if the school nurse determines it is safe/appropriate Yes No

I consent to have the School Nurse, or designee, administer the above medication to my child. I give permission to the School Nurse to share information relevant to the prescribed medication administration as he/she determines appropriate for my son’s/daughter’s health and safety. I understand I may retrieve the medication from the school at any time; however, the medication will be destroyed if it is not picked up within one week following termination of the order or one week beyond the close of school.

Parent/Guardian Signature Date

Phone

home work cell