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________________________

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.

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)