SCHOOL HEALTH SERVICES

PRESCRIPTION MEDICATION ADMINISTRATION FORM
(PHYSICIAN'S SIGNATURE REQUIRED)

Requires renewal at the beginning of each school year

Name of Student _____ D.O.B._____

Address _____ Telephone _____

Parent/Guardian Name _____ School _____

We encourage medication/treatment hours be arranged outside of school hours if possible.

Diagnosis _____

Name of medication/treatment _____

Dose _____

Time(s) to be administered at school _____

Method (route) of administration _____

Medication to be administered from _____ to _____
Month/Day/Year Month/Day/Year

Precautions and reactions to observe and report _____

_____ _____ _____
Physician's Signature Telephone Date

_____ _____
PRINT Physician's Name Clinic Name

(Changes may be called to the school nurse by the prescribing provider with written confirmation following within 24 hours. Faxes are acceptable.)

I authorize personnel at the above named school to administer the medication prescribed on this form to my child. I understand the medication must be provided in the original properly labeled container. I understand that the school district and individuals involved will not be held liable for any adverse effects of the medication. I give permission for communication that may be necessary between the prescribing provider and the eSchool Nurse to insure safe medication administration for my child. I am responsible to pick up unused medication one week after the last dose is given during the school year, and/or before the last day of school. If the medication is not picked up, it will be destroyed.

Parent/Guardian Signature _____ Date _____