SCHOOL HEALTH OFFICE

2022-2023

STUDENT MEDICATION FORM

1. ONE (1) MEDICATION PER FORM – Required for all medication (prescription and over the counter)
2. Form is required to be completed each school year AND when anything changes
3. Medication must be submitted in the original container with pharmacy label (if prescription)
4. Medication must be locked in the Health Office (unless an alternate plan is made with the school nurse)

Student Name: ____ Birthdate: ______/______/______ Grade: ________

Medication Name: ____________________________________ Concentration: ______________________________

Dose: _________________________ Route: ____________ Frequency/Time: _______________________________

Indication/Instructions for "as needed" medication: ____

PARENT/GUARDIAN PORTION

I request this medication be given as prescribed (above) including on field trips. I release school personnel from any liability in the administration of this medication and understand that I am responsible for communication with the healthcare provider who is ordering this medication. I understand that this medication will not be administered by a school nurse. I understand that this authorization will be effective and need to be renewed each school year. I agree to provide medication in the unopened original container (for over the counter med) / with a printed label from the pharmacy (prescription med) and pick the medication up at the end of the school year (or it will be discarded). I will provide all necessary devices required to administer this medication, if needed (ie: syringes, pill crusher, medcup, mask/tubing, etc). Information may be exchanged with medical providers, emergency personnel, and school staff in order to gather/communicate health information and ensure the student's safety.

For Emergency Medication- The student has been instructed in the proper use and may self-carry / self-administer this medication (circle): Yes No

Parent/Guardian Name: ____ Phone: __________________________

Parent/Guardian Signature: ____ Date: ________________________

PRESCRIBER PORTION

*I certify that this student may receive the medication as indicated above. *In lieu of the prescriber's signature on this form: signed Action/Emergency Plans or alternate written orders are accepted.*

For Emergency Medication- The student has been instructed in the proper use and may self-carry / self-administer this medication (circle): Yes No

Prescriber Name: ____ Phone: ____________________________

Prescriber Signature: ____ Date: _________________________