 **School Health Services**

**Prescription Medication Administered at School**

Attach

Student Picture

If available

 School: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

 School Year:

 Class/Grade:

Student Name: \_\_\_\_\_\_\_\_\_\_\_\_\_\_ D.O.B.:

Student Address: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**To Be Completed by Physician/Healthcare Provider:**

Name of medication: Dose:

Time to be given: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ (during school hours)

Reason for medication: \_\_\_\_\_\_\_\_

Form of medication: \_\_\_ Tablet \_\_\_Liquid \_\_\_Inhaler \_\_\_Nebulizer \_\_\_Other

Start Date: \_\_\_\_\_\_\_\_\_\_\_\_\_ Stop Date: \_\_\_\_\_\_\_\_\_\_\_\_\_

Special Instructions:

Potential adverse reactions to be reported:

**Physician/Healthcare Signature**: \_\_\_\_\_\_\_ Date:

Physician/Healthcare Provider Name: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

 Print Name

Phone: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Fax:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**Parent/Guardian: I give permission for my child to receive this medication at school according to the school district policy and as instructed by my healthcare provider.**

**I agree and am responsible to:**

**• Medication to be delivered to school by parent/guardian, not expired, in its original container and labeled by a pharmacist or healthcare provider**

 **• Tell the school as soon as possible if there is a change in the use of my child’s medicine**

 **• Tell the school if my child gets a new healthcare provider**

**• Have my healthcare provider complete a new medicine form for my child if the medicine or dose changes.**

**I agree for child’s healthcare provider to talk with the school or any school staff person about this medicine. No other part of my child’s medical health will be discussed.**

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

**Parent/Guardian Phone:** \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ **Emergency Alternate Phone:** \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**Clinic Use Only**: Date form received \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Date medication received: \_\_\_\_\_\_\_\_\_\_\_\_\_ Form Complete (Y or N) \_\_\_\_\_\_

Notes: Date Form complete: \_\_\_\_\_\_\_\_\_\_\_\_\_\_