SCHOOL MEDICATION/PROCEDURE FORM

STUDENT INFORMATION (to be filled out by parent/guardian)

Student's Name _____ Birthdate _____

School Year or Effective Dates _____ School _____

Medication/Procedure _____ Dosage _____ Time/Frequency _____

Reason for Medication/Procedure _____

Physican's Name _____

Note: For prescription medication, signed Parent Consent **and** signed Physician's Order required.
For non-prescription medication, signed Parent Consent required.

PARENT CONSENT (Complete for EACH medication or procedure at school. Please review the school handbook for specific information regarding the medication policy.)

I request that this medication/procedure be administered at school.

Medication will be supplied in its original, properly labeled container.

This order is in effect for this school year unless otherwise indicated.

I will notify the school in writing for any changes and obtain a new physician's order for those changes.

I authorize school personnel to exchange information verbally or in writing with my child's physician regarding this medication or the condition for which it is being prescribed.

I release the school district from any liability claims as a result of the administration of this medication or procedure as directed.

Parent/Guardian Signature _____Date _____Phone #_____

PHYSICIAN ORDER (Complete for EACH medication or procedure at school.)

The above medication/procedure is to be administered during the school day in accordance with the above instructions.

Please contact me if the following symptoms occur: _____

_____

Additional Information: _____

For ASTHMA INHALERS: Student may carry inhaler in school. YES NO
For EPINEPHRINE AUTO INJECTORS: Student may carry injector in school. YES NO

Physician Signature _____Date _____Phone #_____