Administration of Medication in School
2022-2023

PRESCRIPTION MEDICATION

Dear Parent or Guardian,

Parent/Guardians of students requesting that any prescription medication be administered during school hours by school staff are requested to provide for the school:

1. the **physician's order**. 2. a **parental release**, and 3. medication supplied in the **original container**.

Student Name: ______________________________ Expiration Date: ____________

Birthdate: ____________________ Grade: ____________ Teacher/Advisor: ___________

PHYSICIAN ORDER FOR ADMINISTRATION OF MEDICATION BY SCHOOL PERSONNEL

**PLEASE HAVE PHYSICIAN FILL OUT OR ATTACH A HARD COPY OF PHYSICIAN ORDER*

I have prescribed the following medication for this student and request that dosages be given during school hours:

Medication: ____________________ Dose: ____________ Route: ________________

Time: ___________ PRN Repeat Frequency: ________________________________

(Morning medication dose _______mg to be given at school, only if student forgets to take it at home.)

For treatment of: ____________________Possible side effects: ____________________

Special Instructions: ______________________________ Last date to be given: ____________

Other medications taken at this time: ____

Medication Allergies: ____

Print Physician's Name: __________________________ Phone: (___)____________________

Physician Signature: ________________________________ Date: ______________

PARENTAL REQUEST FOR ADMINISTRATION OF PRESCRIBED MEDICATION

I request this medication be given as prescribed. I release school personnel from any liability in the administration of this medication at school. I understand that I am responsible for communications with the ordering health care providers about this medication. **I understand that medication will not be administered by a school nurse.**

Please check appropriate spaces below:

☐ Keep this medication in school ☐ Send this medication home each evening

Physician and I agree that this student needs medication on field trips. ☐ Yes ☐ No

I feel my child should carry and self-administer his inhaler. ☐ Yes ☐ No

I feel my child should carry and self-administer his epinephrine (Epi-Pen) ☐ Yes ☐ No

Parent/Guardian Signature: ______________________________ Date: ________________

Home Phone: ______________ Work Phone: ______________ Cell Phone: ______________

To promote safety for your child, medication information may be shared with school personnel working with your child and with 911 personnel, if they are called.

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OVER-THE-COUNTER MEDICATION

Student Name: ____

Birth Date: ____________________ Grade: _____ Advisor/Teacher: ___________________

Parents/Guardians of students request for Administration of OTC medication:

I request that my child be allowed to take:

Name of OTC medication: ____

Dose: ______________________ Time/frequency: _____________________________

Reason for medication: ____

This medication will not be used to mask symptoms of illness. If your child requests this medication for another reason than indicated, a staff person will call you for a verbal order.

You will need to supply an unopened bottle of the requested OTC medication with your child's first and last name on it.

Print Parent/Legal Guardian Name: ____

Parent/Legal Guardian Signature: ____

Home Phone: ______________________ Work Phone: ___________________________

Cell Phone: _________________________ Other Phone: __________________________

To promote safety for your child, medication information may be shared with school personnel working with your child and with 911 personnel, if they are called.