

HEALTH SERVICES

PHYSICIAN FORM FOR ADMINISTRATION OF MEDICATION
AND SELF MEDICATION ADMINISTRATION



THIS FORM IS GOOD FOR UP TO ONE SCHOOL YEAR ONLY.

The following is to be completed by a health care provider (physician/nurse practitioner). No medication of any kind will be given to your child until this information is completed and returned to the school.

- All medication must be in a **pharmacy-labeled container**. **NOTE:** Over the counter medication prescribed by a physician/nurse practitioner must be brought to school in an unopened original container.
- If any changes in medication occur during the school year, a new form must be completed along with a new pharmacy/physician-labeled container and returned to the school.
- **Only one form for each medication is to be used.**
- Medication must be brought to school by a responsible adult. Please **do not send medication by children**.
- A parent signature is required before a student can be assisted with self medication.

TO BE COMPLETED BY PARENT:

Name of student _____ Date of Birth _____

School _____ Grade _____ Teacher _____

I hereby give consent for my child to be assisted in taking the medication described below at school. I also authorize, as needed, the sharing of information related to my child's health between the school nurse (or designee) and the health care provider listed below. I will comply with the policy listed on the back of this form related to dispensing medication at school.

Parent / Guardian Signature _____ Date _____ Home Phone _____ Work Phone _____

Mother's Cell Phone _____ Father's Cell Phone _____

Emergency Contact (Name and Phone) _____

TO BE COMPLETED BY HEALTH CARE PROVIDER ONLY:

Diagnosis for which medication is given _____

Name of medication _____ Dosage _____

Start Date _____ Stop Date _____

Form _____ Route _____ Special Handling Instructions: refrigeration keep out of sunlight other _____

If medication is to be given daily, at what time? _____ A.M. _____ P.M.

Dates must be administered at school:

Every day at school Episodic/Emergency events only Short term (list dates to be given) _____

If medication is to be given "when needed", describe symptoms student will exhibit. _____

How soon can it be repeated? _____

Possible side effects and procedure to follow _____

Physician's/Nurse Practitioner's Name (**Print**) _____

Physician's/Nurse Practitioner's Signature _____ Date _____

Address _____ Zip Code _____

Phone _____ Fax _____

(School Staff Only) Completed form received on _____ By _____

Expiration Date of Medication (if available) _____ Date _____ Signature _____