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 ______________________________

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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 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 Practioner's Signature ______________________________ Date ______________

Address ______________________________ Zip Code ______________

Phone ______________________________ Fax ______________________________

(School Staff Only) Completed form received on ____________________ ***By*** ____________________

Date Signature

Expiration Date of Medication (if available) ______________________________

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