SCHOOL MEDICATION/PROCEDURE FORM

STUDENT INFORMATION:

Student's Name _____ Date of Birth _____ School _____

Medication/Procedure _____ Dosage _____ Time/Frequency _____

School Year or Effective Dates _____ Student's Practitioner _____

Reason for Medication/Procedure _____

PHOTO ID (Optional)

NOTE: **For prescription medication: Signed Parent Consent and signed Practitioner's Order required.**
For non-prescription medication: Signed Parent Consent required.

PARENT CONSENT: Complete for EACH MEDICATION/PROCEDURE at school **(Please review your school's 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 practitioner's order.

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

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

Date _____ Parent/Guardian Signature _____ Telephone Number _____

PRACTITIONER'S ORDER: Complete for EACH PRESCRIPTION MEDICATION/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**

Date _____ Practitioner's Signature _____ Telephone Number _____

PROCEDURE/MEDICATION RECORD

STUDENT: ______________________ **DOB:** __________ **GRADE:** ________

Medication, Dosage, Time: ______________________________________

Start Date: ______________________ **Stop Date:** ______________________

DATE	TIME	INITIALS	OBSERVATIONS	DATE	TIME	INITIALS	OBSERVATIONS

(To be filed in student health folder when medication is discontinued)

Initial	Signature	Initial	Signature
______	____________________	______	____________________
______	____________________	______	____________________
______	____________________	______	____________________

(For District Nurse)