

Dyersburg City Schools

Prescription Medication Administration Form

The School District of Dyersburg City Schools requires that all students who need prescription medication during school hours do the following:

1. Healthcare provider must complete his/her portion of this form.
2. Parent/guardian must sign.
3. Parent/guardian **must bring medication in the original container.**

Name of Student: _____ Grade: _____

Date of Birth: _____ Teacher: _____

TO BE COMPLETED BY HEALTHCARE PROVIDER

Diagnosis: _____

Name of Medication: _____
(Dosage/Route/Times at School)

Intended Effect of Medication: _____

Possible Side Effects: _____

Special Instructions for Storage and Handling: _____

Termination date (if applicable): _____

Healthcare Provider Name: _____ Phone: _____

Address: _____

Healthcare Provider Signature: _____ Date: _____

*The Healthcare Provider may be a Medical Doctor (M.D./D.O.), Dentist (D.D.S.), Physician Assistant (P.A.), or Nurse Practitioner (N.P.).

TO BE COMPLETED BY PARENT OR GUARDIAN

**During school hours, the school nurse or individual designated by the school nurse has my permission to administer the medication prescribed.

**I understand that all medications provided to the school for use must be labeled by pharmacist and that any change requires a new form and healthcare provider signature.

**My child is competent to self-administer his/her medication with assistance.

Parent/Guardian Signature: _____ Date: _____

Phone number: _____