

**SCHOOL MEDICATION  
ADMINISTRATION  
FORM**



**OWOSSO PUBLIC SCHOOLS**  
*Ready for the World*

**Student Name:** \_\_\_\_\_  
**Date of Birth:** \_\_\_\_\_  
**School & Grade Level:** \_\_\_\_\_

**The order is valid for school year:**  
\_\_\_\_\_

**This form must be completed fully in order for schools to administer the required medication. A new medication administration form must be completed at the beginning of each school year, for each medication, and each time there is a change in dosage or time of administration of a medication.**

- Prescription medication must be in a container labeled by the pharmacist or prescriber.
- Non-prescription medication must be in the original container with the label intact.
- A parent or guardian must bring the medication to the school.

	<b>Medication Name:</b>	<b>Dose:</b>	<b>Time to be Given:</b>	<b>Form/Route*:</b>	<b>Side Effects:</b>	<b>Adverse Reactions:</b>
1						
2						

\*Route: oral (pill/capsule/chewable/liquid), inhaled (inhaler, nebulizer), topical skin application, eye or ear drop/ointment, other

Medication #1 \_\_\_\_\_ Medication #2 \_\_\_\_\_  
Reason for Medication(s): \_\_\_\_\_  
Start/Stop date if not the beginning of the school year: \_\_\_\_\_

PARENT/GUARDIAN AUTHORIZATION I/We request designated school personnel to administer the medication as prescribed by the above prescriber. I/We certify that I/we have legal authority to consent to medical treatment for the student named above, including the administration of medication at school. I/We understand that at the end of the school year, an adult must pick up the medication, otherwise it will be discarded. I/We authorize the school nurse to communicate with the health care provider as allowed by HIPAA.

Parent/Guardian Signature: \_\_\_\_\_  
Date: \_\_\_\_\_ Cell Phone #: \_\_\_\_\_

**SELF CARRY/SELF ADMINISTRATION OF MEDICATION AUTHORIZATION/APPROVAL**

Self-carry/self-administration of medication (including emergency medication) may be authorized by the prescriber and must be approved by the school nurse according to the School Nurse Program medication policy.

*Physician Signature:* \_\_\_\_\_ *Date:* \_\_\_\_\_

Physician Printed Name: \_\_\_\_\_ Physician Phone: \_\_\_\_\_

*Parent/Guardian Signature:* \_\_\_\_\_ *Date:* \_\_\_\_\_

**School RN approval for self-carry/self-administration of medication:**

School Nurse Signature: \_\_\_\_\_ Date: \_\_\_\_\_