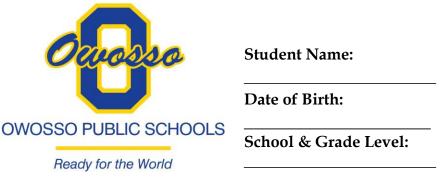
SCHOOL MEDICATION ADMINISTRATION FORM



Form/Route*:

Side Effects:

Adverse Reactions:

The order is valid for school year:

Medication Name:

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.

Time to be Given:

Dose:

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2						
*Rou	te: oral (pill/capsule/chew	vable/liquid), ir	nhaled (inhaler, nebuliz	er), topical skin ap	plication, eye or ea	ar drop/ointment, othe
Me	dication #1		Medic	cation #2		
Rea	nson for Medication(s):	:				
Sta	rt/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 #:						
	Date:		Cell Pho	ne #:		_
Self	LF CARRY/SELF Alf-carry/self-administration must be approved by the	on of medicati	ion (including emerge	ency medication)	may be authoriz	ed by the prescriber
Ph	ysician Signature:				Date:	
Physician Printed Name: Physician Phone:						
Parent/Guardian Signature:			Date:			
	School	l RN approva	al for self-carry/self	-administratior	of medication:	:
Sch	ool Nurse Signature			Г)ate:	