Administration of Medication
TRIPOLI COMMUNITY SCHOOL DISTRICT

_____ _____ _____
Student's Name (Last, First) **Birthday** **DATE**

School medications and health services are administered following these guidelines:

- Parent has provided a signed, dated authorization to administer medication and/or provide the health service.
- The prescribed medication is in the original, labeled container as dispensed.
- The prescription medication label contains the student's name, name of the medication, the medication dosage, time(s) to administer, route to administer, and date.
- Authorization is renewed annually and as soon as practical when the parent notifies the school that changes are necessary.

_____ _____ _____ _____
Prescribed Medication ***Dosage*** ***Route*** ***Time at School***

Special Health Services and instructions, if indicated:
_____

Administration instructions:
_____

Special Directives, Signs to Observe and Side Effects:
_____

Discontinue/ReEvaluate/Follow-up Date for Prescribed Medication or Special Health Services Listed _____

Prescriber's Signature _____***Date***_____

Parent/Guardian _____

Parent/Guardian Signature _____*Date* _____