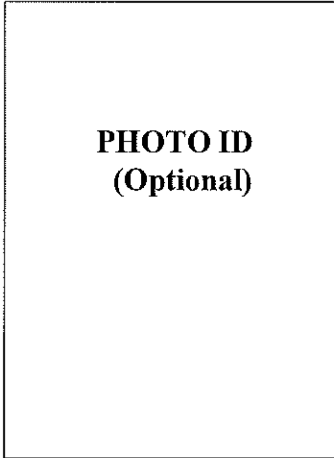
# SCHOOL MEDICATION /PROCEDURE FORM

**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 ______

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 #

**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 inhaler—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 #

# MEDICATION RECORD

**Student's name:** ______________________________ **Date of Birth:** _______________ **Grade/Pod:** ______

**Medication, Dosage, Time:** ________________________________________________________________

**Start Date:** __________________________________ **Stop Date:** _________________________________

| DATE | TIME | INITIALS | OBSERVATIONS | DATE | TIME | INITIALS | OBSERVATIONS |
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**To Be Filed in Student Health Folder When Medication is Discontinued.**

**For District Nurse Use**

| INITIALS | SIGNATURE | INITIAL | SIGNATURE |
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