SCHOOL HEALTH OFFICE

2024-2025

STUDENT MEDICATION FORM

1. ONE (1) MEDICATION PER FORM – Required for all medication (prescription and over the counter)
2. Form is required to be completed each school year AND when anything changes
3. Medication must be submitted in the original container with pharmacy label (if prescription)
4. Medication must be locked in the Health Office (unless an alternate plan is made with the school nurse)

Student Name: _____ Birthdate: _____/_____/_____ Grade: _____

Medication Name: _____ Concentration: _____

Dose: _____ Route: _____ Frequency/Time: _____

Indication/Instructions for "as needed" medication: _____

PARENT/GUARDIAN PORTION

I request this medication be given as prescribed (above) including on field trips. I release school personnel from any liability in the administration of this medication and understand that I am responsible for communication with the healthcare provider who is ordering this medication. I understand that this medication will not be administered by a school nurse. I understand that this authorization will be effective and need to be renewed each school year. I agree to provide medication in the unopened original container (for over the counter med) / with a printed label from the pharmacy (prescription med) and pick the medication up at the end of the school year (or it will be discarded). I will provide all necessary devices required to administer this medication, if needed (ie: syringes, pill crusher, medcup, mask/tubing, etc). Information may be exchanged with medical providers, emergency personnel, and school staff in order to gather/communicate health information and ensure the student's safety.

For Emergency Medication- The student has been instructed in the proper use and may self-carry / self-administer this medication (circle): Yes No

Parent/Guardian Name: _____ Phone: _____

Parent/Guardian Signature: _____ Date: _____

PRESCRIBER PORTION

*I certify that this student should receive the medication as indicated above. *In lieu of the prescriber's signature on this form: signed Action/Emergency Plans or alternate written orders are accepted.*

For Emergency Medication- The student has been instructed in the proper use and may self-carry / self-administer this medication (circle): Yes No

Prescriber Name: _____ Phone: _____

Prescriber Signature: _____ Date: _____