SCHOOL HEALTH OFFICE

2025-2026

STUDENT MEDICATION FORM

ONE (1) MEDICATION PER FORM – Required for all medication (prescription and over the counter)

1. Form is required to be completed each school year AND when anything changes
2. Medication must be submitted in the original container with pharmacy label (if prescription)
3. 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 that this medication be administered as directed, including during field trips. I hereby release school personnel from any liability associated with administering this medication and acknowledge that I am responsible for communicating with the healthcare provider. I understand that a school nurse will not administer this medication and that this authorization is valid for the current school year only and must be renewed annually. I agree to provide the medication in its unopened original container (over-the-counter) or with a printed pharmacy label (prescription). I will retrieve unused medication at the end of the school year; otherwise, it will be discarded. I will provide any necessary devices required for medication administration (ie: syringe, pill crusher, medicine cup, and mask/tubing). Information may be exchanged with medical providers, emergency personnel, and school staff to gather or 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 (select): 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 (select): Yes No

Prescriber Name: _____ Phone: _____

Prescriber Signature: _____ Date: _____