

# SCHOOL MEDICATION /PROCEDURE FORM

## STUDENT INFORMATION:

STUDENT'S NAME	DATE	SCHOOL
MEDICATION/PROCEDURE	DOSAGE	TIME/FREQUENCY
EFFECTIVE DATES	STUDENT'S PHYSICIAN	
REASON FOR MEDICATION/PROCEDURE		

**NOTE:** For prescription medication: Signed Parent Consent and signed Physician's Order required.  
For non-prescription medication: Signed Parent Consent required.

## PARENT CONSENT: Complete for each medication/procedure at school.

- 1) I request that this medication/procedure be administered at school.
- 2) **Medication will be supplied in its original, properly labeled container.**
- 3) This order is in effect for this school year unless otherwise indicated.
- 4) I will notify the school in writing of any changes and obtain a new physician's order.
- 5) I authorize school personnel to contact my child's physician if needed.
- 6) 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 #

## PHYSICIAN ORDER: Complete a form for EACH PRESCRIPTION MEDICATION/PROCEDURE.

The above medication/procedure is to be administered/performed during the school day in accordance with the above instructions.

Please contact me if the following symptoms occur: \_\_\_\_\_

Additional information: \_\_\_\_\_

For Asthma Inhalers **ONLY** : Student may carry inhaler in school **YES / NO**

DATE PHYSICIAN SIGNATURE TELEPHONE #

**PRINCIPAL ORDER:** I authorize \_\_\_\_\_ to administer the medication or perform the procedure as stated above.

DATE PRINCIPAL SIGNATURE