Cambridge School District
Administering Medication to Students

Must be completed for both prescription and non-prescription prior to administration

(Please return to your child's school)

Student Name_____ Physician's Name_____

Birth date_____ Male_____ Female_____ Physician's Address_____

School_____ Grade_____ _____

Teacher (if applicable)_____ Physician's Phone_____

Parent/Guardian_____ Physician's Fax_____

Home Phone_____ Work Phone_____

Cell Phone_____

To Parent/Guardian/Physician:

The Cambridge School District is required by state statue to give prescription medication to students only with the complete directions from a physician and signed consent by parent/guardian. Medication must be supplied in the original container or packaging. For safety and liability reasons, medication received in any container other than the original will not be acceptable for staff administration. By signing this form, you release the Board of Education, its agents and employees from any and all liability which may result from taking this medication.

Start Date_____ End Date_____
Beginning of school year (BOSY) End of School Year (EOSY)

Medication_____ Dosage_____ Frequency_____

Medication Expiration Date (if applicable)_____

Form: □ Tablet/Capsule □ Liquid □ Inhaler □ Nebulizer □ Injection □ Other_____

□ For episodic/emergency events only. (Emergency medications such as: inhaler, glucagon, insulin, Epi-pen).

Student to self-administer/carry: □ Yes □ No

Time(s) to be given_____ Reason for this medication_____

If given on an "as needed" basis, please describe_____

Special instructions_____

Side effects (expected or predictable)_____

Physician's Signature_____ Date_____
(Signature required for all prescription medication and for non-prescription medication that exceeds the manufacturer's recommended dosage).

Parent/Guardian Signature_____ Date_____
(Signature required for all prescription and non-prescription medication).

District Fax: 608-423-9869