SCHOOL MEDICATION/PROCEDURE FORM

STUDENT INFORMATION (to be filled out by Parent/Guardian)

Student's Name _____ Birthdate _____ School _____

Medication/Procedure _____ Dosage _____ Time/Frequency _____

School Year or Effective Dates _____ Student's Physician _____

Reason for Medication/Procedure _____

Medication allergies _____

PHOTO ID
(Optional)

NOTE: For prescription medication: Signed Parent Consent and signed Physician's Order are 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 physician's order.
- I authorize school personnel to exchange information verbally or in writing with my child's physician regarding this medication or the condition for which is it 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 # _____

PHYSICIAN 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 ONLY – Student may carry inhaler in school (circle one) YES NO

Date _____ Physician's Signature _____ Telephone # _____