Form sent to Nurse:

SCHOOL MEDICATION/PROCEDURE FORM

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

Student Name Birthdate School

Medication/Procedure Dosage Time/Frequency

Start Date Stop Date Student's Physician

Reason for Medication/Procedure

PHOTO ID (optional)

Note: For prescription medication: Signed Parent Consent and signed Physician's Order required.
For over-the-counter 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 and Summer PACK 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 it is prescribed.

I release the school district from any liability claims as a result of the administration of this medication or procedure as directed.

I agree to be legally bound by this electronic signature and understand that my electronic signature is the equivalent of a manual signature.

Date Parent/Guardian Signature Telephone #

PHYSICIAN ORDER: Complete for EACH 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:____

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Additional information:____

______________ ____ ____________________

Date Physician's Signature Telephone #

For Asthma inhalers ONLY – Student may carry inhaler in school YES NO