Student Name: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Grade: \_\_\_\_\_\_\_ School Year: \_\_\_\_\_\_\_\_\_\_\_

Student Date of Birth:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Teacher:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

School medications are considered health services and are administered following these guidelines:

1. The prescribing physician fills out the identified section of this form below, or sends in the prescription on their office’s form.
2. The medication is in the original container with the correct pharmacy label detailing the student’s name, name of medication, directions for use, and physician’s name attached. This label must match the physician section of this form. OTC medication will be brought in an unopened container and given per physician orders or according to directions on the medication.
3. Parent signs and dates this form for authorization to administer medication on this form.
4. Medication is scheduled to be given when school is in session during the school hours of 8:30AM-3:30PM. If school is not in session when a medication is scheduled it will NOT be given.
5. This form will be updated by the parent and physician if the medication, dosage, or time administered changes. A new form is required at the start of each school year.

By signing below you are requesting that the above named student be given the medication at school and school activities by qualified staff, according to the prescription as written on this form and the pharmacy label, or by the dosage directions in the case of OTC medications. The student has not experienced any known side effects or allergic reaction to this medication.

You further agree that school personnel may contact the prescriber as needed and that medication information may be shared with school personnel on a need-to-know basis.

You understand that the law provides that there shall be no liability for civil damages as a result of the administration of the medication where the person administering the medication acts as an ordinarily reasonably prudent person would under the same or similar circumstances.

 You agree to provide safe delivery of the medication and equipment to school. Any remaining medication at the end of the school year will be picked up on the last school day or it will be properly disposed of.

**\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**

Parent/ Guardian Signature Date

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Phone Number Emergency Contact and Phone Number

The following section **MUST** be filled out by the **PHYSICIAN**

**Student Diagnosis: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**

**Medication: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**

**Dosage: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_Route:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**

**Time of Administration: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**

**(Please do not use “morning”/”afternoon”, give in HH:MM format or “at lunch”)**

**Is the student authorized to medicate himself/herself (Ex: Inhaler)? YES NO**

**Prescriber’s Phone Number: \_\_\_\_\_\_\_\_-\_\_\_\_\_\_\_\_- \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_Ext: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**

**Prescriber’s Name (Print): \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**

**Prescriber’s Signature: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_Date: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**