## Medication Administration in School

The parent/guardian of _____ asks that the school nurse give the
(Child's Name)

following medication: _____ at _____
(Name of medicine and dosage)                                                          (Time(s))

to my child, according to the Health Care Provider's signed instructions on the lower part of this form.

The program agrees to administer medication prescribed by a licensed healthcare provider.  It is the parent/guardian's responsibility to furnish the medication.  No medication may be brought to the school by a child/student. The parent agrees to pick up expired or unused medication by the end of the school year.

Prescription medications must come in a container labeled with: the child's name, name of medicine, time medicine is to be given, dosage and date medicine is to be stopped, and licensed health care provider's name.  The pharmacy name and phone number must also be included on the label.

Over-the-counter medication must be labeled with the child's name.  Dosage must match the signed health care provider authorization and medicine must be packaged in the original container.

By signing this document, I give permission for my child's healthcare provider to share information about the administration of this medication with the nurse or school staff delegated to administer medication.


_____          _____          _____
Parent/Legal Guardian's Name                       Parent/Legal Guardian Signature                       Date


_____          _____
Parent/Legal Guardian Cell Phone                   Parent/Legal Guardian Other Phone

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## Health Care Provider Authorization to Administer Medication in School

Child's Name: _____          Birthdate: _____

Medication:          _____

Dosage:          _____          Route: _____

To be given at the following time(s): _____

Special Instructions: _____

Purpose of Medication: _____

Side effects of medication that need to be reported: _____

Starting Date: _____          Ending Date: _____

Signature of Health Care Provider: _____          Date: _____

Health Care Provider's Stamp:

STU 508 (6/16)          *Please ask the pharmacist for a separate medicine bottle to keep at school*

# Medication Policy

**Medication at School**

If it is necessary for your child to receive medication during school hours, written permission signed by the attending physician is required. This permission should include the following:

1.   Reason for medication

2.   Name of medication

3.   Dosage to be given

4.   Time medication is to be administered.

The medication must be brought to the nurse's office by an adult, in a closed container properly labeled with the child's name, medication, dosage and time to be given.  Along with this should be the physician's written statement and parental permission.

**PERMISSION FORM IS ON REVERSE SIDE.**

**\*\* Epipens and asthma medications require specific forms; contact the school nurse to obtain these forms.**