SCHOOL MEDICATION /PROCEDURE FORM

STUDENT INFORMATION:

Student's Name	Date of Birth	School
Medication/Procedure	Dosage	Time/Frequency
School Year or Effective Dates	Student's Practitioner	
Reason for Medication/Procedure		

PHOTO ID (Optional)

Note: For prescription medication: Signed Parent Consent and signed Practitioner's Order 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 practitioner's order.

I authorize school personnel to exchange information verbally or in writing with my child's practitioner 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.

Date _____ Parent/Guardian Signature _____ Telephone # _____

PRACTITIONER'S 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—Student may carry inhaler in school **Yes** **No**

For Epinephrine Auto Injectors—Student may carry injector in school **Yes** **No**

Date _____ Practitioner's Signature _____ Telephone # _____