

## School Health Services Prescription Medication Administered at School

Attach Student Picture If available	School Year: _				
Student Name:		D.O.B.:			
Student Address	5:				
To Be Complete	d by Physician/Healt	ncare Provider:			
Name of medica	ation:	_	Dose:		
Time to be given: (during school hours)					
Reason for med	ication:				
Form of medica	tion: Tablet	LiquidInhale	erNebulizerOther		
Start Date:		Stop Date:	_		
Special Instructi	ons:				
Potential advers	se reactions to be repo	orted:			
Physician/Healthcare Signature:			Date:		
Physician/Healt	hcare Provider Name:				
Phone:	Print Name				
policy and as in I agree and am • Delive provide • Tell th	structed by my health responsible to: er my child's medicine r ne school as soon as p	ncare provider. to school in its original con	nedication at school according to the school district tainer and labeled by a pharmacist or healthcare n the use of my child's medicine		

• Have my healthcare provider complete a new medicine form for my child if the medicine or dose changes.

I agree for child's healthcare provider to talk with the school or any school staff person about this medicine. No other part of my child's medical health will be discussed.

Parent/Guardian Signature:	Date:				
Parent/Guardian Phone:	Emergency Alternate Phone:				
**THIS FORM WILL EXPIRE AT THE END OF THE SCHOOL YEAR**					
Clinic Use Only: Date form received	Date medication received:	Form Complete (Y or N)			
Notes:	Date	Form complete:			
	- / / /				

7/09, 4/10, 7/12, 2/13, 11/13, 1/14, 6/14, 6/15, 5/18