Medication Administered at School

Chippewa Local School District

School Year: _____

Student Name:_____ **DOB:** _____
Grade: _____

To Be Completed by Physician/Healthcare Provider:

Name of medication: _____ Dose: _____
Time to be given (during school hours): _____

Reason for medication: _____
Form of medication: ____Tablet ____ Liquid ____Inhaler ____Nebulizer ____

Other Start Date: _____ Stop Date: _____Student May Self-Carry/Self-Administer _____

Special Instructions:_____
Potential adverse reactions to be reported: _____
Physician/Healthcare Provider Signature:
_____Date:_____
Physician/Healthcare Provider Printed Name: _____
Phone: _____ Fax: _____

Parent/Guardian: I give permission for school staff to administer this medication as instructed by my child's healthcare provider. I agree I am responsible to: *Deliver my child's medication to school in the original container, labeled by a pharmacist or healthcare provider. *Tell the school as soon as possible if there is a change in the use of my child's medication. *Tell the school if my child gets a new healthcare provider. *Have my child's healthcare provider complete a new form if my child's medication or dose changes, or notify the school in writing if the medication is no longer needed. I agree for my child's healthcare provider to talk with school staff about this medication. No other part of my child's medical health will be discussed unless my specific consent is given.

Parent/Guardian Signature:
_____Date:_____
Parent/Guardian Phone: _____

****THIS FORM WILL EXPIRE AT THE END OF THE SCHOOL YEAR****

Clinic Use Only: Date form received _____ Date medication received _____
Date/initial additional medication received: _____ _____ _____ _____
_____ _____ _____ _____ _____