

SCHOOL MEDICATION/PROCEDURE FORM

STUDENT INFORMATION: (to be filled out by Parent/Guardian)

Student's Name	Birthdate	School	PHOTO ID (Optional)
Medication/Procedure	Dosage	Time/Frequency	
School Year or Effective Dates	Student's Physician		
Reason for Medication/Procedure			

*Note: For prescription medication: Signed **Parent Consent** and signed **Physician'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, updated, 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 physician's order.
- I authorize school personnel to exchange information verbally or in writing with my child's physician regarding this medication or the condition for which it is prescribed.
- I release the school district and school personnel from any liability claims as a result of the administration of this medication or procedure as directed.

Date	Parent/Guardian Signature	Telephone Number
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PHYSICIAN 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 inhalers ONLY - Student may carry inhaler in school YES NO

Date	Physician's Signature	Telephone Number
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