Medication Administration Form

Student's Name: ________________________ Date of Birth: ______________ Grade: ______________

Medication Information:

Check ONE		Medication Name	Dose/How much to give: List mg, mcg, or other measurement	When to give: Ex: "at lunch," "2pm," or "every 4 hours PRN for pain"
Daily	As Needed			

Over the counter medications (such as tylenol, benadryl, or ibuprofen) do not need a medical provider's signature. All prescription medications including epipens and inhalers must have a medical provider's signature.

TO BE COMPLETED BY MEDICAL PROVIDER (if prescription medications are listed above)

Practitioner Printed Name: ________________________________ Phone: ______________

Clinic/Health care system: ________________________________ Fax: ______________

Practitioner Signature: ________________________________ Date: ______________

TO BE COMPLETED BY PARENT/GUARDIAN:

I give consent for school personnel to administer medication as described above. I authorize communication between the prescribing health care provider, the school nurse, and trained school personnel necessary for the management and administration of this medication. I have read the procedures outlined in board policy 5330 and assume responsibilities as required.

Parent/Guardian Signature: ________________________________ Date: __________

TO BE COMPLETED BY SCHOOL STAFF:

Verify all when medication is delivered to school:

☐ All above information is completed, including signatures.
☐ Medication is in original packaging with clear dosing instructions/prescription label.
☐ Written instructions above match written instructions on medical packaging.

Staff signature: ________________________________ Date: ______________