ANKENY CHRISTIAN ACADEMY

Medication Administration Form
Parental Permission to Self-Carry/Self-Administer

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"	Check if Self-Carrying
Daily	As Needed				
☐	☐				
☐	☐				
☐	☐				
☐	☐				

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 Student Handbook and assume responsibilities as required.

Parent/Guardian Signature: _____ Date: _____

FOR HIGH SCHOOL STUDENTS SELF-CARRYING *EMERGENCY MEDICATION ONLY*:

I give consent for my student to self-carry and administer the prescription medication listed above in case of emergency. I understand all other medications must be administered by school staff. I have reviewed the school's medication policy and agree to follow the self-carry guidelines. I understand that if my student does not follow the medication policy they will lose the privilege of being able to self-carry and administer medication and be subject to disciplinary action.

Parent/Guardian Signature: _____ Date: _____

I agree to take personal responsibility for the medication listed above. I have reviewed the school's medication policy and agree to follow the self-carry guidelines. I understand that if I do not follow the medication policy I will lose the privilege of being able to self-carry and administer medication.

Student 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: _____