

# Medication Administration Form For School

The parent/guardian of \_\_\_\_\_ asks that school staff give the following medication \_\_\_\_\_ during school hours according to the Health Care Provider's signed instructions on this form.

The school agrees to administer medication prescribed by a licensed health care provider. It is the parent's responsibility to furnish the medication on a regular basis. The parent agrees to pick up the expired or unused medication within one week of notification by school staff.

## **Prescription medications must come in a pharmacy-labeled container.**

By signing this document, I give permission for my child's health care provider to share information about the administration of this medication with the nurse or school staff delegated to administer medication.

\_\_\_\_\_  
Parent/ Guardian name                      Parent/ Guardian signature                      Date

\_\_\_\_\_  
Day phone #    Home phone #

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## **Health Care Provider Authorization to Administer Medication in School**

Child's Name: \_\_\_\_\_ Birthdate: \_\_\_\_\_

Medication (name, dosage, route): \_\_\_\_\_

To be given at the following time(s) during school: \_\_\_\_\_

Purpose of this medication: \_\_\_\_\_

Side effects to be reported: \_\_\_\_\_

Additional special instructions: \_\_\_\_\_

Starting Date: \_\_\_\_\_ Ending Date: \_\_\_\_\_

\_\_\_\_\_  
**Signature of Health Care Provider with Prescriptive Authority**                      **License Number**

\_\_\_\_\_  
**Phone Number**    **Date**

Please ask the pharmacist for a separate medicine bottle to keep at school.  
Thank you!