

Put in your schools name or business here

## Medication Administration in School

The parent/guardian of \_\_\_\_\_ ask that the school staff give the  
(Child's name)  
following medication \_\_\_\_\_ at \_\_\_\_\_  
(Name of medicine and dosage) (Time(s))  
to my child, according to the Health Care Provider's signed instructions on the lower part of this form.

The school agrees to administer medication prescribed by a licensed health care provider.

It is the parent/guardian's responsibility to furnish the medication.

The parent agrees to pick up expired or unused medication within one week of notification by staff.

**Prescription medications** must come in a container labeled with: child's name, name of medicine  
Time medicine is to be given, dosage, date medicine is to be stopped, and licensed health care provider's  
name. Pharmacy name and phone number must also be included on the label.

**Over the counter medication** must be labeled with child's name. Dosage must match the signed  
health care provider authorization, and medicine must be packaged in the original 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. \*The first dose of any  
medication should be administered at home prior to sending it to school.\*

\_\_\_\_\_  
Parent/Legal Guardian's Name

\_\_\_\_\_  
Parent/Legal Guardian Signature

\_\_\_\_\_  
Date

\_\_\_\_\_  
Work Phone

\_\_\_\_\_  
Home Phone

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

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

Medication: \_\_\_\_\_ Dosage: \_\_\_\_\_

Route: \_\_\_\_\_ To be given at the following times(s): \_\_\_\_\_  
May repeat medication every \_\_\_\_\_ hours

Purpose of Medication: \_\_\_\_\_

Special instructions (storage, may student carry med, etc.): \_\_\_\_\_

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

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

\_\_\_\_\_  
Signature of HCP with Prescriptive Authority

\_\_\_\_\_  
License Number

\_\_\_\_\_  
Phone Number

\_\_\_\_\_  
Date

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