SCHOOL MEDICATION/PROCEDURE FORM

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

Student's Name	Birth date	School
Medication/Procedure	Dosage	Time/Frequency
School Year or Effective Dates	Student's Physician	

Reason for Medication/Procedure

Medication Allergies:

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, 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 physicians 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 from any liability claims as a result of the administration of this medication or procedure as directed.

Date	Parent/Guardian Signature	Telephone #

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:

For Asthma inhalders ONLY - Student may carry inhaler in school Yes No

Date	Physician's Signature	Telephone #