Medication Form

Medication Administration

School personnel may administer medication when such treatment is necessary for school attendance and cannot otherwise be accomplished. This completed form along with the medication and/or special equipment items are brought to the school by the parent.

- The medication must be brought to school in original, properly labeled containers. The pharmacy can supply two (2) labeled bottles for this purpose. Medication sent in Baggies will not be administered.
- Medications will not be given without a specific written request signed by at least one parent or legal guardian and physician. This request should be made on the appropriate form supplied by the school.
- All medications must be kept with a designated director or chaperone, except for students whose doctor requires them to carry medication (such as inhalers) on their person. An additional prescription of the medication must be kept with the designated director or chaperone in charge of administering medication. If a student allows another person to use their medication, the privilege will be revoked.
- Over-the-counter medications require a parent signature and that the medication has been given before with no known allergies. The medication can only be given as directed by the manufacturer and must be FDA approved.

Physician Request For Administration of Medication during School Hours

Name of Student_____ DOB _____ Date _____

Name of School _____ Grade _____ Start Date _____ End Date _____

Physician Name _____ Signature _____

Physician Address_____ Phone # _____-_____-_____

Medication Name _____ Medication Dose _____

Medication Administration Time _____ Medication Frequency _____

Diagnosis_____

Comments: _____

Prescription Medication

We (I), the undersigned, the parents/guardians of _____ request the above medication:
(Students name)

☐ be held and administered by a school employee to my child. ☐ held and administered by my child.

_____/_____Telephone _____-_____-_____/_____-_____-_____
Name Relationship Home Business

Over-the-counter medication

I understand my child may require an over-the-counter medication while on this trip. The medications will ONLY be administered according to the directions on each medication bottle and with parent's authorization.

Medication Name _____ Medication Dose _____

Medication Administration Time _____ Medication Frequency _____

I do / do not (circle) authorize my child to receive Tylenol _____(parent signature)

I do / do not (circle) authorize my child to receive Motrin _____(parent signature)

_____/_____Telephone _____-_____-_____/_____-_____-_____
Name Relationship Home Business