

**PARENT AND PRESCRIBER'S AUTHORIZATION FOR
ADMINISTRATION OF MEDICATION IN SCHOOL**

Use only one form for each medication prescribed.

A. To be completed by the parent or guardian:

I request that my child _____ grade _____ receive the medication as prescribed below by our licensed health care prescriber.

The medication is to be furnished by me in the properly labeled original container from the pharmacy.

I understand that the school nurse, or other designated person in the case of the absence of the school nurse, will administer the medication.

Signature (Parent or Guardian): _____ Date: _____

Telephone: Home _____ Work _____ Allergies: _____

I understand that the nurse will notify all appropriate staff of my child's allergies. I am aware that this open communication is necessary in protecting my child from a potentially serious, life-threatening allergic reaction. I will inform the nurse of any changes in my child's status, i.e.: new allergies.

B. Self-medication release form (For Inhaler or Epi-Pen Only)

Above student is permitted to carry the medication on his/her person, as we consider him/her responsible. He/she has been instructed in and understands the purpose, appropriate method and frequency of use.

Physician's signature _____

Parent or Guardian's signature _____

C. To be completed by the licensed health care prescriber:

I request that my patient, as listed below, receive the following medication:

Name of Student: _____ Date of Birth: _____

Diagnosis: _____

Name of Medication: _____

Dosage: _____ **Frequency:** _____ **Route of Administration:** _____

Possible Side Effects and Adverse Reactions (if any): _____

Other Recommendations: _____

Name of Licensed Prescriber and Title (please print): _____

Prescriber's Signature: _____ Date: _____

Address: _____ Phone: _____

SCHOOL HEALTH SERVICES
DAILY MEDICATION SHEET FOR 2020-2021 SCHOOL YEAR

Name: _____ Medication: _____ Doctor: _____ Date: _____
 Dose: _____ Time: _____

SEPTEMBER

Week	Date	M	T	W	TH	F
1	9/1-4					
2	9/7-11					
3	9/14-18					
4	9/21-25					
5	9/28-30					

OCTOBER

Week	Date	M	T	W	TH	F
1	10/1-2					
2	10/5-9					
3	10/12-16					
4	10/19-23					
5	10/26-30					

NOVEMBER

Week	Date	M	T	W	TH	F
1	11/2-6					
2	11/9-13					
3	11/16-20					
4	11/23-27					
5	11/30					

DECEMBER

Week	Date	M	T	W	TH	F
1	12/1-4					
2	12/7-11					
3	12/14-18					
4	12/21-25					
5	12/28-31					

JANUARY

Week	Date	M	T	W	TH	F
1	1/1					
2	1/4-8					
3	1/11-15					
4	1/18-22					
5	1/25-29					

FEBRUARY

Week	Date	M	T	W	TH	F
1	2/1-5					
2	2/8-12					
3	2/15-19					
4	2/22-26					
5						

MARCH

Week	Date	M	T	W	TH	F
1	3/1-5					
2	3/8-12					
3	3/15-19					
4	3/22-26					
5	3/29-31					

APRIL

Week	Date	M	T	W	TH	F
1	4/1-2					
2	4/5-9					
3	4/12-16					
4	4/19-23					
5	4/26-30					

MAY

Week	Date	M	T	W	TH	F
1	5/3-7					
2	5/10-14					
3	5/17-21					
4	5/24-28					
5	5/31					

JUNE

Week	Date	M	T	W	TH	F
1	6/1-4					
2	6/7-11					
3	6/14-18					
4	6/21-25					
5						

COMMENTS

NURSE'S SIGNATURE INITIAL DATE
