Healthcare Provider Form For Administration of Medication (Nursing) Or Assistance with Self Administration of Medication (School Staff)

THIS FORM IS GOOD FOR ***ONE SCHOOL YEAR ONLY.***

The following is to be completed by a healthcare provider (physician, nurse practitioner, dentist, etc). No medication of any kind will be given to your child until this information is completed and returned to the school. Remember, all medication must be in a **pharmacy-labeled container**. Over the counter medication prescribed by a health care provider must be brought to school in an unopened, labeled, original container. If any changes in medication occur during the school year, a new form must be completed along with a new pharmacy/physician-labeled container and returned to the school. **Only one form for each medication is to be used.** Medication must be brought to school by a responsible adult. Please **do not send medication by elementary children.** A parent signature is required before a student can be assisted with the self-administration of medication or medication can be administered to the student.

TO BE COMPLETED BY PARENT:

Student Name_______________________________ Date of Birth________ Allergies__________________________

School____________________________________ Grade______________ Teacher___________________________

Parent/Guardian's Name_______________________ Date___________ Preferred phone #_______________________

Parent/Guardian's Signature ____________________________________ Alternate phone#______________________

Preferred Local Hospital In Case of Emergency:____

I give permission for my child to administer, be administered by, or assisted with the self-administration of the medication by school nurse or trained school personnel. This includes both in school and on field trips. The school nurse has my permission to share the information provided with appropriate members of the educational team on a "need to know" basis in a confidential manner. A parent/guardian signature includes permission for the nurse to communicate with the provider who signs the Medication Order Form regarding any questions. The school, its employees and agents shall incur no liability as a result of injury sustained by the student or any other person from possession or self-administration of his/her medication. The school shall incur no liability and the parent/guardian shall indemnify and hold harmless the school and its employees against any claims relating to the possession or self-administration of the medication. Any unused medication will be destroyed at the end of the current school year if not retrieved by parent/guardian.

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TO BE COMPLETED BY HEALTHCARE PROVIDER:

Name of Medication________________________________Dosage______________Route__________________________

Diagnosis/reason for which medication is given____

If medication is to be given daily, at what time?______________AM ______________PM

If medication is to be given "PRN/when needed", describe symptoms____

Is refrigeration necessary? Yes/ No. How soon can it be repeated?____

Possible side effects and procedure to follow____

Healthcare Provider's Name (Please Print)____

Healthcare Provider's Signature _____________________________________ **Date**___________________________

Address____ **Phone** __________________ **Fax** _________________

(School Staff Only) Completed Form Received On_____________By____