STUDENT MEDICATION FORM

STUDENT INFORMATION

Student Name: _____ Date of Birth: _____

Address: _____

City: _____ State: _____ Zip: _____

Parent Name: _____ Email: _____

Home Phone: _____ Mobile Phone: _____

EMERGENCY CONTACT INFORMATION

Name: _____ Phone: _____ Relation: _____

Name: _____ Phone: _____ Relation: _____

Name: _____ Phone: _____ Relation: _____

PARENT/GUARDIAN RELEASE

☐ I hereby authorize school staff to administer the medication described below to my child. I understand that a trained teacher or other school personnel will administer only the medication(s) described below. If the prescription is changed, a new parent consent form and a new health practitioner order must be completed before the school staff can administer the new medication.

Prescription medication must be transported to and from school by an adult, in the current original pharmacy container and label, with the child's name, medication name, administration time, dosage, and health care provider's name. If it is an over the counter medication, the medication must be in the original store container. School personnel may contact the student's health care provider if clarification is needed to administer this medication.

☐ I authorize my child to carry, be in possession of, and self-administer this medication.

My child and I understand there are serious consequences, which may include suspension or expulsion for sharing any medications and/or supplies with others.

I agree to meet the parental responsibilities listed above. I understand that school personnel may release personal or medical information about my child in a health-related situation if necessary. **NOTE:** A new medication form will be required at the beginning of every school year.

_____ _____

Parent/Guardian Signature Date

SALT LAKE ARTS ACADEMY 844 SOUTH 200 EAST SALT LAKE CITY, UT 84111 PHONE: 801.531.1173 FAX: 801.531.7726

MEDICATION INFORMATION (HEATLH CARE PROVIDER ONLY)

NAME OF MEDICATION	INDICATION	DOSAGE	METHOD	TIME

PHYSICIAN RELEASE

Physician's Name: _____ Phone: _____

The above named student is under my care:

☐ In my opinion, this medication is necessary during the school day. Trained school personnel should and will be allowed to administer this medication.

Please list any specific training required: _____

_____

☐ In my opinion, this medication is necessary during the school day. I feel it is medically appropriate for the student to be in possession of, and self-administer this medication.

Duration medication is to be administered / or student is allowed to carry the medication: _____

_____

Common side effects: _____

_____

Allergies: _____

_____

NOTICE: This order can only be signed by an MD; Dentist; Nurse Practitioner (NP, FNP, PNP, APRN/PP), Certified Physician's Assistant or a provider with Prescriptive Practice.

_____ _____

Physician's Signature Date

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