# Physician 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 health care 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:**

Name of Student_____Date of Birth_____Allergies_____
School_____Grade_____ Teacher_____

I give permission for my child to be administered or assisted in the self-administration of the medication listed below by authorized persons. My child's medical condition is stable and my child is competent to self administer this medication with assistance. This includes both at school and on field trips. The school nurse has my permission to share the information provided with appropriate members of the educational team. This will be done only on a "need to know' basis in a confidential manner. A parent/guardian signature includes permission for the nurse to communicate with the provider listed below regarding any questions.

| _____ | _____ | _____ | _____ | _____ |
|---|---|---|---|---|
| Date | Parent/Guardian Signature | Home Phone | Work Phone | Emergency Contact Name/Phone |

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**TO BE COMPLETED BY PHYSICIAN:**

Name of Medication_____Dosage_____Route_____
Diagnosis/reason for which medication is given_____
If medication is to be given daily, at what time?_____A.M._____P.M._____
If medication is to be given "when needed", describe symptoms_____
Is refrigeration necessary? Yes/ No. How soon can it be repeated?_____
Possible side effects and procedure to follow_____
Health Care Provider's Name (**Please Print**)_____
Health Care Provider's Signature _____Date_____
Address_____Telephone_____Fax _____

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**(School Staff Only) Completed Form Received On_____By_____**

Physician Form For Administration of Medication: 8/04; Revised 5/05, 7/07; Reviewed: 02/11.