2025-2026 Medication Administration Request

Medication at School: Whenever possible the parent and Health Care Provider will design a schedule for giving medication outside of school hours. Medications are ordered to be given at school only when necessary. Medication, unless otherwise directed to be carried by the student, will be kept in a designated secure area and administered by the school nurse or trained personnel.

Student Name:_____ DOB:_____ Grade:_____

Diagnosis or reason for medication:_____

Name of Medication	Dosage	Method of Administration	Time to be Taken
_____	_____	_____	_____
_____	_____	_____	_____

If given PRN, specify the length of time between doses: _____

Possible side effects of medication:_____

Emergency procedure in case of serious side effects:_____

Inhalers:_____ Dosage: _____ Time Taken: _____

Indicate if student may carry on their person: Yes_____ No_____

Student is capable of self-administration of medication: Yes_____ No_____

Epi-Pen:_____ Dosage: _____ Time Taken: _____

Indicate if student may carry on their person: Yes_____ No_____

Student is capable of self-administration of medication: Yes_____ No_____

Emergency Plan is in place for follow-up: Yes_____ No_____

Length of time this authorization is valid: From_____ To_____

I request and authorize the above named student to be administered the medication in accordance with the above instructions:

Health Care Provider Signature and Date:_____

Health Care Provider Name (Please Print):_____ Phone#:_____ Fax#:_____

Parent Permission: Must be signed by parent or guardian.

I request that my child be allowed to take medication as described above. The medication is to be furnished by me in the original container and BROUGHT TO SCHOOL BY AN ADULT. Prescription medications must be labeled by the pharmacy with the name of the student, health care provider, medication, dosage and the time of day to be given. I understand that my signature indicates my understanding that the school accepts no liability for untoward reaction when the medication is administered in accordance with the health care provider's directions. This authorization is good for the current school year only. Any change in medication, dose, or time must be handled as a new medication and anew order form completed by both the parent and health care provider. The school may discontinue administration of the medication with proper advance notice. I am the parent of child named:_____

Date of Signature:_____ Parent/Guardian Signature_____

Telephone Number: (Home)_____ (Work)_____ (Cell)_____