MEDICATION PERMISSION AND ADMINISTRATION FORM

TEACHER: _____

STUDENT NAME: _____ PHONE: _____

DATE: _____ PARENT SIGNATURE: _____

PRESCRIPTION AND NON-PRESCRIPTION MEDICATION

NAME OF MEDICATION: _____

DOSE: _____ STRENGTH: _____

TIME TO BE ADMINISTED: ☐ SPECIFIC TIME: _____

☐ AS NEEDED per Physicians Orders

POSSIBLE SIDE EFFECTS: _____

1. No medications will be administered to a student without written permission from parent or guardian. This form must be signed and on file for each child who recieves a medication at school.
2. New authorization is needed at the beginning of each school year.
3. According to school policy, medications administered at school will be limited to ingested medications unless specific care plans are on file and approved by a school nurse.
4. All medications MUST be brought to school by a parent or guardian
5. All medications must be in the original container. School personnel wil NOT administer unlabeled medications, not if the original container, to a student.
6. The pharmacy or physician must appropriately label prescription medications. The label must include: Child's name, doctor, medication and dosage
7. No medications are to be kept with the student except those required for asthma or allergic reaction. Specific authorization forms must be filled out for inhalers and EPI pens These are available in your school office.
8. The parent or guardian must pick up unused medications. At the conclusion of the school year, all medications that have not been picked up will be properly disposed of.

MONTH	1	2	3	4	5	6	7	8	9	10	11	12	13	14	15	16	17	18	19	20	21	22	23	24	25	26	27	28	29	30	31
AUGUST																															
SEPT																															
OCTOBER																															
NOVEMBER																															
DECEMBER																															
JANUARY																															
FEBRUARY																															
MARCH																															
APRIL																															
MAY																															
JUNE																															

MEDICATION CHANGE				
DATE	CHANGED TO	DOSAGE	TIME ADM.	INITIAL

CODES

X: NO SCHOOL
A: ABSENT
D/C: MEDICATION DISCONTINUED
FT: FIELD TRIP
E: EARLY
W: DOSE
R: REFUSED
N: NO MEDICATION
S: SUSPENDED
O: NO SHOW

STUDENT _____

SIGNATURE OF PERSON(S) ADMINISTERING MEDICATION	INITIALS
1)	
2)	
3)	
4)	

MEDICATION INTAKE LOG

MEDICATION	DATE	DOSE	AMOUNT RECEIVED	INITIALS

Comments: (document any unusual circumstances, parent contact, actions or omissions, therapeutic and adverse reactions. Date each separate entry.)

DATE AND SIGNATURE	SITUATION OR PROBLEM	INTERVENTION