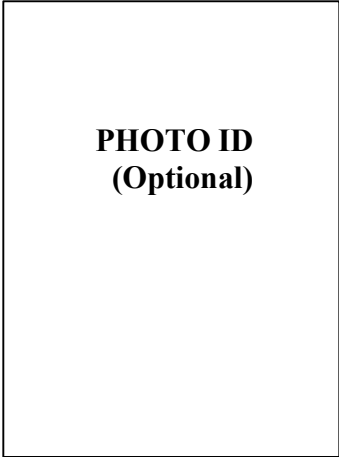


# SCHOOL MEDICATION /PROCEDURE FORM

**STUDENT INFORMATION:**

Student's Name	Date of Birth	School
Medication/Procedure	Dosage	Time/Frequency
School Year or Effective Dates	Student's Practitioner	
Reason for Medication/Procedure		



Note: For prescription medication: Signed Parent Consent and signed Practitioner's Order required.  
 For non-prescription medication: Signed Parent Consent required.

**PARENT CONSENT: Complete for EACH MEDICATION/PROCEDURE at school (Please review your school's handbook for specific information regarding the medication policy.)**

*I request that this medication/procedure be administered at school.*

*Medication will be supplied in its original, properly labeled container.*

*This order is in effect for this school year unless otherwise indicated.*

*I will notify the school in writing for any changes and obtain a new practitioner's order.*

*I authorize school personnel to exchange information verbally or in writing with my child's practitioner regarding this medication or the condition for which it is prescribed.*

*I release the school district from any liability claims as a result of the administration of this medication or procedure as directed.*

Date	Parent/Guardian Signature	Telephone #
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**PRACTITIONER'S ORDER: Complete for EACH PRESCRIPTION MEDICATION/PROCEDURE at school.** The above medication procedure is to be administered during the school day in accordance with the above instructions.

Please contact me if the following symptoms occur: \_\_\_\_\_  
 \_\_\_\_\_

Additional information: \_\_\_\_\_

<b>For Asthma inhaler—Student may carry inhaler in school</b>	<b>Yes</b>	<b>No</b>
<b>For Epinephrine Auto Injectors—Student may carry injector in school</b>	<b>Yes</b>	<b>No</b>

Date	Practitioner's Signature	Telephone #
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