

**Medication Administered at School**

Chippewa Local School District

School Year: 2021-2022

**Student Name:** \_\_\_\_\_ **DOB:** \_\_\_\_\_

Grade: \_\_\_\_\_

**To Be Completed by Physician/Healthcare Provider:**

Name of medication: \_\_\_\_\_ Dose: \_\_\_\_\_

Time to be given (during school hours): \_\_\_\_\_

Reason for medication: \_\_\_\_\_

Form of medication: \_\_\_ Tablet \_\_\_ Liquid \_\_\_ Inhaler \_\_\_ Nebulizer \_\_\_

Other Start Date: \_\_\_\_\_ Stop Date: \_\_\_\_\_ Student May Self-Carry/Self-Administer \_\_\_\_\_

Special Instructions: \_\_\_\_\_

Potential adverse reactions to be reported: \_\_\_\_\_

**Physician/Healthcare Provider Signature:**

\_\_\_\_\_ Date: \_\_\_\_\_

Physician/Healthcare Provider Printed Name: \_\_\_\_\_

Phone: \_\_\_\_\_ Fax: \_\_\_\_\_

Parent/Guardian: I give permission for school staff to administer this medication as instructed by my child's healthcare provider. I agree I am responsible to: \*Deliver my child's medication to school in the original container, labeled by a pharmacist or healthcare provider. \*Tell the school as soon as possible if there is a change in the use of my child's medication. \*Tell the school if my child gets a new healthcare provider. \*Have my child's healthcare provider complete a new form if my child's medication or dose changes, or notify the school in writing if the medication is no longer needed. I agree for my child's healthcare provider to talk with school staff about this medication. No other part of my child's medical health will be discussed unless my specific consent is given.

Parent/Guardian Signature:

\_\_\_\_\_ Date: \_\_\_\_\_

Parent/Guardian Phone: \_\_\_\_\_

**\*\*THIS FORM WILL EXPIRE AT THE END OF THE SCHOOL YEAR\*\***

Clinic Use Only: Date form received \_\_\_\_\_ Date medication received \_\_\_\_\_

Date/initial additional medication received: \_\_\_\_\_

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