

Henry W. Moore School
Medication Administration Form

PARENT/GUARDIAN PLEASE FILL OUT:

Name of student _____ DOB _____
Teacher _____ Grade _____
Name of medication _____
Dose to be given _____ RX # _____
Time and frequency of med. To be given _____
Reason med. Is given _____
Doctor prescribing _____
Beginning _____ to _____ (list dates)

The medication **MUST** be delivered to the School Nurse or Principal's Office by a parent or responsible adult. All medication is to be in a container properly labeled with student's name, MD name, name and dosage of medication.

I authorize the School to assist my child in taking the above medication. I will not hold liable any member of the school staff or an individual of official capacity who is directed by myself (the parent/guardian) and the school administrator to assist my child in taking said medication.

Parent/Guardian signature _____ Date _____
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PHYSICIAN PLEASE FILL OUT:

Name of student _____ Diagnosis _____
Medication/Dosage _____ time schedule _____
Medication to be taken beginning _____ to _____ (dates)
Licensed Provider Signature _____ Date _____
Printed name _____
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FOR METERED DOSE INHALERS OR EPIPEN MEDICATION ONLY;

IF YOU REQUEST THAT YOUR CHILD CARRY HIS/HER INHALER OR EPIPEN WITH THEM,
PLEASE HAVE THE FOLLOWING COMPLETED.

PHYSICIAN PLEASE FILL OUT:

I have instructed _____ in the proper way to use _____
It is my professional opinion that he/she should be allowed to carry and use that medication by his/herself without supervision. YES NO
Licensed provider signature _____ Date _____

PARENT/GUARDIAN:

I agree with the above physician's statement that my child has been instructed in the proper way to use this medication and should be allowed to carry and use that medication by him/herself without supervision. I give my child permission to do so. YES NO

IMMEDIATELY AFTER USING THE EPIPEN OR INHALER, DURING THE SCHOOL DAY, THE STUDENT MUST REPORT TO THE NURSE, OR OFFICE, FOR APPROPRIATE FOLLOW-UP CARE.

Parent/Guardian signature _____ Date _____