**Medication Administration Form for Prescription Medication**

The Parent/Guardian of _____ requests that the school nurse or designated staff member give the following medication _____ during school hours according to the health care providers instructions on this form.

The school agrees to administer medication as prescribed by the healthcare provider. It is the parent's responsibility to provide medication on a regular basis. Controlled substances will not be sent with more than one week of medication at a time. When required, the parent agrees to pick up the medication within one week of notification by school staff or it will be disposed of.

***Prescription medication must come in a labeled container from the pharmacy***

By signing this document I give permission for the medical office to share information about the administration of this medication to the school nurse or designated support staff that may handle the medication.

_____ _____ _____

Parent/Guardian Name Parent/Guardian Signature Date

**Healthcare Provider's Authorization to Administer Medication During School Hours**

Child's Name: _____ Birthdate: _____

Medication (name, route, dose) _____

To be given at the following time at school: _____

Purpose of the medication: _____

Side effects of the medication:_____

Additional instructions:_____

Starting Date:_____ Ending Date:_____

_____ _____

Signature of Heathcare Provider Date

_____

Phone Number

Please ask pharmacist to for a separate medication bottle for mediation that will be given at school