

SCHOOL HEALTH SERVICES

**PRESCRIPTION MEDICATION ADMINISTRATION FORM  
(PHYSICIAN'S SIGNATURE REQUIRED)**

**Requires renewal at the beginning of each school year**

Name of Student \_\_\_\_\_ D.O.B. \_\_\_\_\_

Address \_\_\_\_\_ Telephone \_\_\_\_\_

Parent/Guardian Name \_\_\_\_\_ School \_\_\_\_\_

**We encourage medication/treatment hours be arranged outside of school hours if possible.**

Diagnosis \_\_\_\_\_

Name of medication/treatment \_\_\_\_\_

Dose \_\_\_\_\_

Time(s) to be administered at school \_\_\_\_\_

Method (route) of administration \_\_\_\_\_

Medication to be administered from \_\_\_\_\_ to \_\_\_\_\_  
Month/Day/Year Month/Day/Year

Precautions and reactions to observe and report \_\_\_\_\_

\_\_\_\_\_  
**Physician's Signature** Telephone Date

\_\_\_\_\_  
**PRINT Physician's Name** Clinic Name

(Changes may be called to the school nurse by the prescribing provider with written confirmation following within 24 hours. Faxes are acceptable.)

I authorize personnel at the above named school to administer the medication prescribed on this form to my child. I understand the medication must be provided in the original properly labeled container. I understand that the school district and individuals involved will not be held liable for any adverse effects of the medication. I give permission for communication that may be necessary between the prescribing provider and the eSchool Nurse to insure safe medication administration for my child. I am responsible to pick up unused medication one week after the last dose is given during the school year, and/or before the last day of school. If the medication is not picked up, it will be destroyed.

Parent/Guardian Signature \_\_\_\_\_ Date \_\_\_\_\_