STUDENT MEDICATION FORM

GRADE

STUDENT NAME:

Missouri Laws allow our school nurse or other designated school personnel to assist students who are required to take medication during the school day. This service is provided to enable the student to remain in school to maintain or improve the potential for education and learning.

Medication must be in the original container in which it was purchased with the pharmacy, label attached, and must be currently prescribed for the student to whom it will be administered. No medications (including over-the-counter medications) will be given at school without these current written instructions. *The first dose of medication is not to be administered by school personnel.*

Child's Name: _____ **Grade:** _____

Date of Birth: _____

TO BE COMPLETED BY HEALTH CARE PROVIDER

Date of Examination: _____ **Diagnosis:** _____

Medication Prescribed: _____

Dosage: _____ Time: _____ Route: _____

Side Effects to Note: _____

Over the Counter Medications: _____

Acetaminophen: _____Yes (dosage); **Ibuprofen:** _____ Yes (dosage), every 4-6 hours for fever/pain/headache.

It is necessary for this medication to be taken during the school day at the time(s) indicated above and unlicensed, trained school personnel may administer the medication listed above.

Physician's Signature: _____

Physician's Printed Name: _____

Address: _____ **Date:** _____

_____ **Phone:** _____

TO BE COMPLETED BY PARENT/GUARDIAN

I authorize school personnel to administer the above medication to my child as ordered by the Health Care Provider. I also authorize the school nurse to consult the Health Care Provider named above about my child's medication needs.

Parent/Guardian signature: _____ **Date:** _____

Printed Name: _____

Home Address: _____

_____

Phone Number: _____