Royall School District

Medication/Procedure Administration Form

Medications are to be administered at home whenever possible. If it is necessary to receive medications at school, all appropriate portions of this form must be completed before medications can be given at school. One form is required for each medication.

Student_____ Birthdate _____

School_____Grade_____ School year:_____

MEDICATION/PROCEDURE

Name of Medication or Procedure_____

Reason for medication/Procedure _____

Dosage_____ Time_____ Frequency_____

Route (circle one): Mouth Inhaled Injected

Dates to be given: _____ to _____

Any additional directions_____

Precautions/unfavorable reactions reactions _____

PARENT/GUARDIAN CONSENT: (complete for ALL medications/procedures at school)

**I request and authorize that this medication be administered at school by school personnel*

**I will supply medication in its original, updated, properly labeled container (Request extra bottle from pharmacy)*

**I will obtain a new physician's order and notify the school in writing for any changes.*

**I authorize school personnel to exchange information verbally or in writing with my child's physician regarding this medication or the conditions for which it is prescribed.*

**I further understand that all medication should be delivered to school by parent, guardian or responsible adult. If medications are sent to school with my student, I accept responsibility/accountability for the risk of discrepancies during transport*

**I understand that medication may be given by non-medically trained personnel.*

**I agree to hold Royall School District, its employees and agents who are acting within the scope of their duties harmless in any way and all claims arising from the administration of this medication at school.*

****My signature indicates that I have fully read and understand the above information.***

_____

Signature of Parent/Legal Guardian *Telephone #* *Date*

PHYSICIAN ORDER: (Complete for all Prescription Medication/Procedures)

The above medication/procedure is to be administered/performed during the school day in accordance with the above instructions and agreements. I agree to accept communication about student/medication/procedure and understand medication will be given by non-medically trained school personnel.

Student and parent/guardian have been instructed in self-administration and student may carry **inhaler or Epi-pen** and self-administrator at school. Yes____ No____

Clinic _____Phone #_____ Fax # _____

Physician Name _____

*Physician's Signature*_____ *Date* _____