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Richland School District Medication Administration Form

Medications are to be administered at home whenever possible. If it is necessary for a student to receive a medication at school, this form must be completed before the medication can be given at school. One form is needed for each required medication.

Name of Student: ___________________________________Date of Birth: _________________Grade: _________

Name of Medication: ____

PARENT/GUARDIAN CONSENT

- I request and authorize that Richland School District personnel administer this medication at school.
- I understand that non-medically trained school personnel may give this medication.
- I will supply medication in its original, updated, properly labeled container (Request extra bottle from the pharmacy).
- I will obtain a new practitioner's order each school year, when any changes are made, or when the order is terminated.
- I authorize Richland School District personnel to exchange information verbally and/or in writing with my child's practitioner regarding this medication or the conditions for which it is prescribed.
- I understand that all medications will be kept in a secure location in the health office unless otherwise ordered below.
- I understand that all medications are to be transported to and from school by the parent/guardian.
- My signature indicates that I have fully read and understand the above information.

____ _____________________________ __________________
Signature of Parent/Legal Guardian Telephone Date

To Be Completed by the Prescribing Practitioner

PRACTITIONER ORDER Required for all prescription medications and nonprescription medications to be given in a dosage other than the recommended therapeutic dose. *Separate orders may also be faxed to the school office.

Medication Name: __________________________________ Diagnosis: _____________________________________

Start Date: _____________________ Stop Date (end of school year unless otherwise specified): __________________

Time of Administration at School: _____________________________ Dose at School: __________________________

Administration Instructions (Route, other): ____

If the medication is to be given on an as needed basis (PRN), state conditions under which this medications is to be given:

____

Possible Side Effects/Adverse Reactions: ____

The above medication is to be administered during the school day in accordance with the above instructions. I understand that non-medically trained school personnel may give this medication.

ASTHMA INHALERS AND EPINEPHRINE AUTOINJECTORS ONLY: I have provided instruction to this student and their parent/guardian in self-administration of this medication and this student may carry this inhaler or epinephrine autoinjector and self-administer at school as needed. ☐ Yes ☐ No

____ _____________________________ _______________
Practitioner Signature Telephone Date