Akron Children's Hospital

**SCHOOL HEALTH SERVICES**

Attach Student Picture If available

## Prescription Medication Administered at School

School: _____

School Year: _____

Class/Grade: _____

Student Name: _____ D.O.B.: _____

Student Address: _____

**To Be Completed by Physician/Healthcare Provider:**

Name of medication: _____ Dose: _____

Time to be given: _____ (during school hours)

Reason for medication: _____

Form of medication: ☐ Tablet ☐ Liquid ☐ Inhaler ☐ Nebulizer ☐ Other

Start Date: _____ Stop Date: _____

Special Instructions: _____

Potential adverse reactions to be reported: _____

_____

**Physician/Healthcare Signature**: _____ Date: _____

Physician/Healthcare Provider Name: _____
Print Name

Phone: _____ Fax: _____

**Parent/Guardian: I give permission for my child to receive this medication at school according to the school district policy and as instructed by my healthcare provider.**

I agree and am responsible to:

- Deliver my child's medicine to school in its original container and labeled by a pharmacist or healthcare provider
- Tell the school as soon as possible if there is a change in the use of my child's medicine
- Tell the school if my child gets a new healthcare provider
- Have my healthcare provider complete a new medicine form for my child if the medicine or dose changes.

I agree for child's healthcare provider to talk with the school or any school staff person about this medicine. No other part of my child's medical health will be discussed.

Parent/Guardian Signature: **Print for signature** _____ Date: _____

Parent/Guardian Phone: _____ Emergency Alternate Phone: _____

****THIS FORM WILL EXPIRE AT THE END OF THE SCHOOL YEAR****

**Clinic Use Only**: Date form received _____ Date medication received: _____ Form Complete (Y or N) _____

Notes: _____ Date Form complete: _____

7/09, 4/10, 7/12, 2/13, 11/13, 1/14, 6/14, 6/15