Akron Children's Hospital

## School Health Services
## Prescription Medication Administered at School

Attach Student Picture If available

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: _____

**<u>Parent/Guardian:</u> 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**: _____ **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