

SOUTHWESTERN CONSOLIDATED SCHOOLS

ADMINISTRATION OF MEDICATIONS DURING SCHOOL HOURS RELEASE FORM

Student Name _____ Grade _____

Name and quantity of medication brought to school _____

Dose (mg, mL) _____

Route (oral, topical, rectal) _____

Frequency (how often can this be given) _____

Circle one: PRN (as needed) or given routinely

Duration (how long is this order valid) _____
(Full school year or a limited time?)

This form must be completed for each separate medication that you want the school to administer.

Please read the following and sign below.

Southwestern Elementary / High School personnel have my consent to administer the medication listed above, per the directions that I have specified above. I also understand that at the end of the school year, it is my responsibility to pick up any medications that may be left over. The school nurse will contact me in the spring to remind me of this. I acknowledge that these may not be left at the school over summer nor sent home with my child.

Parent/Guardian Signature

Date

Student Medication Self-Administration Statement (to be completed by your health care provider)

As a student at Southwestern, my patient demonstrates the ability and responsibility to safely self-administer the medication listed above and may carry it on his/her person or in his/her belongings.

Physician Signature

Date