

# S-9: Student Medication Form

## STUDENT INFORMATION

Student Name: \_\_\_\_\_ Date of Birth: \_\_\_\_\_ School: \_\_\_\_\_  
 Address: \_\_\_\_\_ City: \_\_\_\_\_ State: \_\_\_\_\_ Zip: \_\_\_\_\_  
 Home Phone: \_\_\_\_\_ Mobile Phone: \_\_\_\_\_ Email: \_\_\_\_\_

## EMERGENCY CONTACT INFORMATION

Name (other than parent/guardian): \_\_\_\_\_ Phone: \_\_\_\_\_

## PARENT/GUARDIAN RELEASE

- I hereby authorize school staff to administer the medication described below to my child. I understand that a trained teacher or school employee will administer only the medication(s) described below. If the prescription is changed, a new parent consent form and a new health practitioner order must be completed before the school staff can administer the new medication.

Prescription medication must be transported to and from school by an adult, in the current original pharmacy container and label, with the child's name, medication name, administration time, dosage, and health care provider's name. If it is an over-the-counter medication, the medication must be in the original store container. The school nurse may contact the student's health care provider if clarification is needed to administer this medication.

- I authorize my child to carry, be in possession of, and self-administer this medication.

My child and I understand there are serious consequences, which may include suspension or expulsion for sharing any medications and/or supplies with others. See [Administrative Procedures](#) for Board Policy S-3: Student Conduct and Discipline.

I agree to meet the parental responsibilities listed above. I understand that school personnel may release personal or medical information about my child in a health-related situation if necessary. **Note:** A new medication form will be required every school year.

\_\_\_\_\_  
 Parent/Guardian Signature \_\_\_\_\_  
Date

## MEDICATION INFORMATION (HEALTH CARE PROVIDER ONLY)

NAME OF MEDICATION	INDICATION	DOSAGE	ROUTE	TIME

The above-named student is under my care:

- In my opinion, this medication is necessary during the school day. Trained school personnel should and will be allowed to administer this medication. Please list any specific training required: \_\_\_\_\_
- In my opinion, this medication is necessary during the school day. I feel it is medically appropriate for the student to be in possession of and self-administer this medication.

Duration medication is to be administered /or student is allowed to carry the medication: \_\_\_\_\_

Common side effects: \_\_\_\_\_

Allergies: \_\_\_\_\_

**NOTICE:** This order can only be signed by an MD; Dentist; Nurse Practitioner (NP, FNP, PNP, APRN/PP), Certified Physician's Assistant or a provider with prescriptive practice.

\_\_\_\_\_  
 Physician's Signature \_\_\_\_\_  
Date