New Prague Area Schools

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Medication Administration Form

Purpose: In order to assure the health and safety of students, this form needs to be completed. A student will only be given medication during school hours, when it is properly prescribed, by a licensed health care provider and requested by a parent.

Procedure: Provide the following for Health Services:

1. A licensed Health Care Provider's Order (DDS, MD, NP, PA).
2. Parent/Guardian request for medication administration.
3. The medication-supplied in the original bottle (ask pharmacist to divide prescription into two bottles) completely labeled-one for school and one for home.

Student Name:_____ **Birthdate**:_____ **Grade**:_____

Circle School: High School - Middle School- CEC - Eagle View - Falcon Ridge - Raven Stream

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Health Care Provider's Order for Medication Administration in School

Medication: _____ Dose:_____ Time: _____*
***If medication is to be given at lunchtime-please write "lunch" for time.*

Begin date: _____ End Date: _____

Student's Diagnosis or for the treatment of:_____

Possible Side Effects:_____

Other special instructions or helpful information:_____

_____

_____

_____

If this is an inhaler or bee sting allergy kit may student carry this with him/her? Yes No

Physician Signature:_____ Date:_____

Clinic Name and Address (print)**:_____**

Clinic Telephone Number:_____

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Parent/Guardian Request for Medication Administration

I request the above medication to be given as prescribed. My signature also authorizes information to be released to and from the above health care provider to and from the school, regarding the above medication/diagnosis/treatment.

Parent/Guardian Signature:_____ Date:_____

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