

**PARENT/GUARDIAN PERMISSION**  
**AND PHYSICIAN ORDER FOR MEDICATION AT SCHOOL**

As a normal and regular practice, school personnel will not administer medicine. Student medicines should be administered at home under parental direction.

In situations when a student's health will be compromised by not receiving this medication during school hours, school district policy and procedures must be followed for the administration of all medication.

- A. Medication is defined as prescription, non-prescription (over the counter) drugs, and herbal preparation.
- B. Administration of **any** medication requires both a physician's written order and signed parental permission.
- C. Prescribed medication must be brought to school in a pharmacy or physician labeled container with the correct name, dose and time to be administered. The parent may want to ask the pharmacist for a second bottle in order to have one at home and one at school.
- D. Medication must be transported to and from school in a safe manner.
- E. The child's physician must complete the bottom section of the form on the reverse side. The parent is responsible for signing and dating the top portion. The completed physician's order and parental permission must be on file at school before any medication is administered.
- F. If there is a change in medication, dose or frequency, it is the parent's responsibility to provide the school nurse with revised physician's instructions in order for the change to take effect; except as noted on the other side.
- G. Unused medication shall either be picked up by the parent/guardian or destroyed at the end of the school year.
- H. School District U-46 may reject requests for administration of medicine.

School District U-46  
Health Services

**MEDICATION PERMISSION AND PHYSICIAN INSTRUCTION**

Student Name: \_\_\_\_\_ Date of Birth: \_\_\_\_\_  
Last Name, First Name Month Day Year

Address: \_\_\_\_\_  
House Number / Street Apt # if necessary City ZIP

School: \_\_\_\_\_ Grade: \_\_\_\_\_ Teacher: \_\_\_\_\_  
Name of School Teacher's Name

**PARENT/GUARDIAN PERMISSION:** (to be completed by parent/guardian)

I give permission to the school nurse and to those persons she has inserviced to administer the medication(s) listed below. I give permission to the school nurse to communicate as warranted with the undersigned physician regarding my child's medication. I understand that the school district and its employees are to incur no liability, except for willful and wanton conduct, as a result of any injury arising from the self-administration of medication by the pupil.

Printed Name: \_\_\_\_\_ Home Phone: \_\_\_\_\_ Work Phone: \_\_\_\_\_  
Parent/Guardian printed name area code + number area code + number

Signature: \_\_\_\_\_ Date of signature: \_\_\_\_\_  
Signature of Parent/Guardian Month Day Year

**PHYSICIAN'S ORDERS:** (to be completed by student's physician)

- Medication:** \_\_\_\_\_  
Dose: \_\_\_\_\_ Frequency: \_\_\_\_\_  
Diagnosis: \_\_\_\_\_  
Side effects: \_\_\_\_\_  
Medical protocol may require an adjustment in dosage of this medication. Verbal orders for increase or decrease in increments of \_\_\_\_\_ are inherent in this order only.
- Medication:** \_\_\_\_\_  
Dose: \_\_\_\_\_ Frequency: \_\_\_\_\_  
Diagnosis: \_\_\_\_\_  
Side effects: \_\_\_\_\_  
Medical protocol may require an adjustment in dosage of this medication. Verbal orders for increase or decrease in increments of \_\_\_\_\_ are inherent in this order only.

I understand that the above medications require annual review and authorization by me. Any changes in medication or dose prior to this review require written authorization.

Signature: \_\_\_\_\_ Date of signature: \_\_\_\_\_  
Signature of Physician Month Day Year

Physician's Printed Name: \_\_\_\_\_  
Physician's printed name Medical Group/Clinic

Office Address: \_\_\_\_\_  
Street Address Suite # if necessary City ZIP

Office Phone: \_\_\_\_\_ Fax Number: \_\_\_\_\_  
area code + number area code + number

*Please return completed form to School Health Office*