MISSISSINEWA COMMUNITY SCHOOLS
HEALTH SERVICES
Medication Administration Form

Student's Name: _____

Birthdate: _____ Grade: _____

Parent/Guardian Name: _____

Name of Medication: _____

Purpose of Medication: _____

Dosage: _____

Time(s) when medication is to be administered: _____

Anticipated length of time student is to receive medication: _____

_____

Physician's Name: _____

I hereby authorize trained school personnel to administer medication as indicated above and agree to inform the school in writing of any change in medication, dosage, or times of administration for the student while at school.

_____ _____
Signature of Parent/Guardian Date

YES NO (please circle) My child may transport their medication to and from school.

_____
Signature of Parent/Guardian

YES NO (please circle) My child may carry and self-administer the above medication at school. **Inhalers and EpiPens are the ONLY** medications allowed to be carried and self-administered by students.

_____
Signature of Parent/Guardian

*__ALL__ medications (including over-the-counter medications) must be accompanied by a doctor's orders; no medication will be administered otherwise

**A copy of the Medication Policy available upon request