Immaculate Conception School
Medication Administration Form
2020-2021

In order to administer prescription medication to your child, this information must be completed, signed and returned to the school nurse on or before September 2, 2020.

Student Name: _____**DOB:** _____ **Grade:** _____

Parent/Guardian Name: _____

Home phone #_____**Cell #**_____**Work #**_____

Name of Licensed Prescriber: _____ **Telephone #**_____

Medical Diagnosis: _____

Food-Drug Allergies (state reaction): _____

TO BE COMPLETED BY PRESCRIBER:

Medication Name: _____

Route of Administration:_____**Dosage:** _____**Time:** _____

Frequency:_____**Time(s) of Administration:** _____

Specific directions (ie: take w/food, on empty stomach etc): _____

Side Effects: _____

All medication must be stored in a prescription bottle labeled by the pharmacy

Permission:
I consent to have the school nurse or school personnel designated by the school nurse administer the above medication. I give permission for the school nurse to share information relevant to the prescribed medication as she determines appropriate for my child's health and safety.

Medication should be sent and administered on field trips: Yes_____ No_____

Child can self-administer medications: PARENTS Yes_____ No_____
Child can self-administer medications: PHYSICIAN Yes_____ No_____
Child can self-administer medications: SCHOOL NURSE Yes_____ No_____

Parent's Signature: _____ **Date:** _____

Prescriber's Signature_____ **Date:** _____

School Nurse Signature: _____ **Date:** _____