

**Immaculate Conception School
Medication Administration Form 2021-2022**

In order to administer a daily 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: _____