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MEDICATION ADMINISTRATION FORM

(To be completed by parent or guardian)

We are the parents or legal guardians of ____.
We request that medicine be administered to our child by a member of the school staff in accordance with our physician's instructions. We will notify the school immediately if we change physicians or if the medication or dosage is changed.

We agree to bring the medication to school in a container from a pharmacist properly labeled including name of the student, doctor, date, dosage, name of medication, and method of administration. Medication improperly labeled or contained, will not be administered at the school.

Parent's Signature ____

Address ____

Home Address ____

Business Phone ____

Date ____

To be filled out by school personnel

____ ______________________________
Director's Signature Date

____ ______________________________
Nurse's Signature Date

(COMPLETE BOTH SIDES)

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UTAH SCHOOLS FOR THE DEAF AND THE BLIND

MEDICATION ADMINISTRATION FORM

To be completed by prescribing practitioner

Student's Name _____________________________________ Birth Date ______________________

Medication/dosage/method of administration _____________________________________
____
Reason for medication ____
Time to be administered ____
Anticipated number of days medication needs to be given at school ___________________
Possible side effects ____
Actions to be taken by school personnel ____
Expected effects on learning ____

Medication/dosage/method of administration _____________________________________
____
Reason for medication ____
Time to be administered ____
Anticipated number of days medication needs to be given at school ___________________
Possible side effects ____
Actions to be taken by school personnel ____
Expected effects on learning ____

Medication/dosage/method of administration _____________________________________
____
Reason for medication ____
Time to be administered ____
Anticipated number of days medication needs to be given at school ___________________
Possible side effects ____
Actions to be taken by school personnel ____
Expected effects on learning ____

The above named student is in need of the above named medication/drug during regular school hours or residential placement, to maintain his/her physical health. I advise and request:

[ ] that non-medical school personnel be allowed to administer this medication/drug

[ ] that said student be allowed to self-administer this medication/drug with the following Instructions: ____

_____________________________________ _____________________________________
Practitioner's Name Telephone

_____________________________________ _____________________________________
Date Prescribing Practitioner's Signature

(COMPLETE BOTH SIDES)