STOW - MUNROE FALLS CITY SCHOOLS

PRESCRIPTION MEDICATION ADMINISTERED AT SCHOOL

Attach Student Picture if Available

School: _____

School Year: _____

Class/Grade: _____

Student Name: _____ D.O.B. _____

Student Address: _____

To Be Completed by Physician/Healthcare Provider:

Name of medication: _____ Dose: _____

Time to be given: _____ (during school hours)

Reason for medication: _____

Form of medication: ☐ Tablet ☐ Liquid ☐ Inhaler ☐ Nebulizer ☐ Other

Start Date: _____ Stop Date: _____

Special Instructions: _____

Potential adverse reactions to be reported: _____

_____

Physician/Healthcare Provider Signature: _____

Physician/Healthcare Provider Name: _____
(Print Name)

Phone: _____ Fax:_____

Parent/Guardian: I give permission for my child to receive this medication at school according to the School District policy and as instructed by my healthcare provider.
I agree and am responsible to:

- Deliver my child's medicine to school in its original container and labeled by a pharmacist or healthcare provider
- Tell the school as soon as possible if there is a change in the use of my child's medicine
- Tell the school if my child gets a new healthcare provider
- Have my healthcare provider complete a new medicine form for my child if the medicine or dose changes.

I agree for my child's healthcare provider to talk with the school or any school staff person about this medicine. No other part of my child's medical health will be discussed.

Parent/Guardian Signature: _____ Date: _____

Parent/Guardian Phone: _____ Emergency Alternate Phone: _____

THIS FORM WILL EXPIRE AT THE END OF THE SCHOOL YEAR

Clinic Use Only: Date form received: _____ Date medication received: _____ Form Complete (Y or N): _____
Notes: _____ Date Form Complete: _____