Faxed: _____
Initials:_____

MSAD#1
Parent Request and Medical Provider Order
Medication Administration in School
Phone: 764-8105 FAX: 768-3085

All medication will be kept in the clinic/office. I am aware that my child's medication will be administered by medical or non-medical school personnel.

Child's Name _____ DOB _____Grade _____

Health Care Provider's Name _____
(Please list Health Care Provider and we will fax this form to their office)

Allergies _____

Reason for medication/diagnosis _____

Name of medication _____

Dosage of medication _____ Time to be given: _____Route _____

List significant side effects _____

_____

Other _____

I give my permission for the school nurse to exchange information with my child's teachers, staff, bus drivers and medical provider(s), as listed above, regarding medication, immunizations and emergency care.

Parent/Guardian Signature _____Date_____Phone _____

Health Care Provider's Review/Signature _____ Date _____

MEDICATIONS MUST BE IN THEIR ORIGINAL CONTAINERS, AS RECEIVED FROM THE PHARMACY. THIS POLICY COVERS ALL PRESCRIPTION AND OVER THE COUNTER MEDICATIONS.