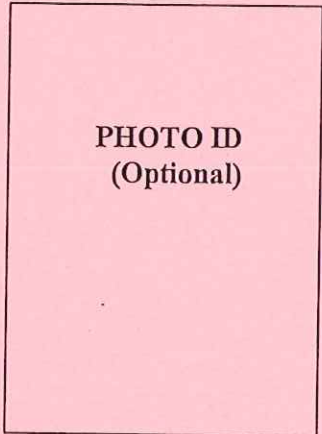


SCHOOL MEDICATION /PROCEDURE FORM

STUDENT INFORMATION:

| | | |
|---------------------------------------|------------------------------|----------------------|
| Student's Name _____ | Date of Birth _____ | School _____ |
| Medication/Procedure _____ | Dosage _____ | Time/Frequency _____ |
| School Year or Effective Dates _____ | Student's Practitioner _____ | |
| Reason for Medication/Procedure _____ | | |



Note: For prescription medication: Signed Parent Consent and signed Practitioner's Order required.
 For non-prescription medication: Signed Parent Consent required.

PARENT CONSENT: Complete for **EACH MEDICATION/PROCEDURE** at school (Please review your school's handbook for specific information regarding the medication policy.)

I request that this medication/procedure be administered at school.

Medication will be supplied in its original, properly labeled container.

This order is in effect for this school year unless otherwise indicated.

I will notify the school in writing for any changes and obtain a new practitioner's order.

I authorize school personnel to exchange information verbally or in writing with my child's practitioner regarding this medication or the condition for which it is prescribed.

I release the school district from any liability claims as a result of the administration of this medication or procedure as directed.

| | | |
|------------|---------------------------------|-------------------|
| Date _____ | Parent/Guardian Signature _____ | Telephone # _____ |
|------------|---------------------------------|-------------------|

PRACTITIONER'S ORDER: Complete for **EACH PRESCRIPTION MEDICATION/PROCEDURE** at school. The above medication procedure is to be administered during the school day in accordance with the above instructions.

Please contact me if the following symptoms occur: _____

Additional information: _____

| | | |
|---------------------------------------------------------------------|-----|----|
| For Asthma inhaler—Student may carry inhaler in school | Yes | No |
| For Epinephrine Auto Injectors—Student may carry injector in school | Yes | No |

| | | |
|------------|--------------------------------|-------------------|
| Date _____ | Practitioner's Signature _____ | Telephone # _____ |
|------------|--------------------------------|-------------------|