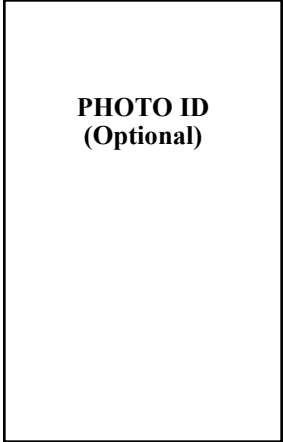


SCHOOL MEDICATION/PROCEDURE FORM

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 Number
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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 inhalers—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 Number
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