Akron Children's Hospital

School Health Services

Non-Prescription Medication Administration at School

Attach Student Picture If available

School: _____

School Year: _____

Class/Grade: _____

Student Name: _____ Date of Birth: _____

Student Address: _____

Name of Medication: _____ Dose: _____

Time to be given (during school hours): _____

Reason for Medication to be administered: _____

Form of Medication: _____Tablet _____ Liquid _____ Other

Start date: _____ Stop date: _____

Special Instructions: _____

Potential adverse reactions to be reported to parent or physician: _____

_____

Physician/Healthcare Provider Name: _____ Phone: _____

Parent/Guardian: I give permission for my child to receive this medication at school according to the school district policy. I agree and am responsible to:

- **Deliver this medicine to schooi in its original container.**
- **Tell the school as soon as possible if there is a change in the use of this medicine.**
- **Complete a new medicine form for this medicine if there are dose changes. If medication dosage does not match the instructions on original container, a healthcare provider order is required.**
- **If this medication is needed for greater than 4 consecutive days a healthcare provider order is required.**

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

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: _____

7/09, 4/10, 6/12, 5/13, 6/14, 6/15, 6/16, 5/18

Akron Children's Hospital

School Health Services
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 Signature: _____ Date: _____

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 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: _____

7/09, 4/10, 7/12, 2/13, 11/13, 1/14, 6/14, 6/15, 5/18