Student Name: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ DOB: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_
Parent Name:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_Phone Number:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**Medication Administration**

 I request that the School Nurse administer the medication prescribed by my child’s physician as stated below. A signed doctor’s order form was provided to the School Nurse. I will provide the medication in the original pharmacy or over the counter container. This plan will be shared with school staff caring for my child.

 I agree that my child can use their medication effectively and may carry and use this medication independently at any school/school
sponsored activity. Staff intervention and support is needed only during an emergency. **RESCUE MEDICATIONS ONLY** (Inhaler, Epi-Pen, Benadryl, Glucagon (Baqsimi)- 7th-12th Grade Only).

Signature: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Date: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**Initial Medication Delivery**

Name of Medication: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Provider Name: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**Controlled Substance: Yes No MD Order Received: Yes No**

Dosage:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_Route:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**Daily/PRN or Duration:**\_\_\_\_\_\_\_\_\_\_Time of Administration:\_\_\_\_\_\_\_\_Q\_\_\_\_\_\_\_\_HRS

Begin Date:\_\_\_\_\_\_\_\_\_\_\_\_\_End Date: \_\_\_\_\_\_\_\_\_\_\_\_ Count Verified by: Staff 1:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Staff 2:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

|  |  |  |  |  |  |  |  |  |  |  |  |
| --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- |
|  | Count | Rec’d By | Date |  | Count | Rec’d By | Date |  | Count | Rec’d By | Date |
| **Medication Type:** |  |  |  |  |  |  |  |  |  |  |  |
| Pills |  |  |  | Liquid |  |  |  |  Eye Drops |  |  |  |
|  Injectables (IM) |  |  |  |  Inhaler |  |  |  |  Topical |  |  |  |
|  Injectables (SQ) |  |  |  |  Nose Spray |  |  |  |  Ampules (Neb) |  |  |  |

Parent/Guardian Initials:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_School Nurse Signature: \_\_\_\_\_\_\_\_

**Medication Pick-Up** Discontinued End of School Year Transferred
 Medication Destroyed Parent Request Failed to Pick-Up
Destroyed by: Staff 1:\_\_\_\_\_\_\_\_\_\_\_\_\_\_Staff 2:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

|  |  |  |  |  |  |  |  |  |
| --- | --- | --- | --- | --- | --- | --- | --- | --- |
|  | Count | Date |  | Count | Date |  | Count | Date |
| **Medication Type:** |  |  |  |  |  |  |  |  |
|  Pills |  |  |  Liquid |  |  |  Eye Drops |  |  |
|  Injectables (IM) |  |  |  Inhaler |  |  |  Topical |  |  |
|  Injectables (SQ) |  |  |  Nose Spray |  |  |  Ampules (Neb) |  |  |

Count Verified by: Staff 1:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Staff 2:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Date Verified:\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Count Verified by Parent (Initial):\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_Staff Initial:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_Date:\_\_\_\_\_\_\_\_\_\_\_\_

Parent/Guardian Signature:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_School Nurse Signature: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**Subsequent Medication Delivery**

**Date:** \_\_\_\_\_\_\_\_\_\_\_\_ Count:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_Count Verified by: Staff 1:\_\_\_\_\_\_\_\_\_\_\_\_ Staff 2:\_\_\_\_\_\_\_\_\_\_\_\_

Received By Initial: \_\_\_\_\_\_\_\_\_\_\_\_Parent / Guardian Initial: \_\_\_\_\_\_\_\_\_\_\_\_ School Nurse Signature:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**Date:** \_\_\_\_\_\_\_\_\_\_\_\_ Count:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_Count Verified by: Staff 1:\_\_\_\_\_\_\_\_\_\_\_\_ Staff 2:\_\_\_\_\_\_\_\_\_\_\_\_

Received By Initial: \_\_\_\_\_\_\_\_\_\_\_\_Parent / Guardian Initial: \_\_\_\_\_\_\_\_\_\_\_\_ School Nurse Signature:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

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Received By Initial: \_\_\_\_\_\_\_\_\_\_\_\_Parent / Guardian Initial: \_\_\_\_\_\_\_\_\_\_\_\_ School Nurse Signature:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

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