Delano Public Schools
Medication Administration Form

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Check the boxes to indicate that you have read and understand the requirements for medication administration at school.

- ❑ Proper completion of the Medication Administration Form
- ❑ Medication supplied:
  - ❑ If it is OTC(Over-the- Counter), the medication must be in a **sealed** container.
  - ❑ If it is a Prescription, the medication must be in the original container.
  - ❑ The medication will NOT be administered if it is expired, please check the expiration date.
- ❑ Medications can be administered for **2 school days** without signed Medication Administration Forms, but beyond that, medications will NOT be given to the student.
- ❑ One form must be completed for each medication.
- ❑ Any OTC medication can only be given **AS DIRECTED** on the bottle, unless a Physician's note or order is supplied.
- ❑ The School Nurse has the right to request a Physician's note or order:
  - ❑ If the student is taking OTC medications frequently
  - ❑ If the student is taking any Aspirin-containing products
- ❑ It is the responsibility of the parent to retrieve any unused or expired medications from the Health Office.
- ❑ If this is completed electronically, the Health Office will obtain a Physician's Signature for any Prescription Medications **if the contact information is provided**.
- ❑ This form will be effective for the duration of the present school year.

Student:_____ **Date of Birth:**_____

Teacher:_____ **Grade:**_____

❑OTC (Over the counter) ❑Prescription

Medication:_____ Dose:_____

Route:_____ Time to administer:_____

Duration:_____ Medical reason for this medication:_____

If this is as needed, how often can it be repeated:_____

Possible side effects of the medication:_____

Medication Allergies:_____

Other medications taken at this time:_____

_____

High School Inhalers ONLY: Student may self-carry ❑Yes ❑No, it should be in the health office

If Prescription ➢ Physician Signature:_____ Date:_____

Physician Printed Name:_____ Phone #:_____

Clinic:_____ Fax #:_____

Field Trip/Off Campus Plan:_____

_____

I request these medications be administered and I give the Health Services Staff authority to communicate with the ordering Physician about this medication. I release school personnel from any liability in the event of reactions resulting from administration of this medication at school.

Parent/Guardian Signature:_____ **Date:**_____