Twin Cities Academy

CREATING A HIGHER STANDARD OF ACADEMIC EXCELLENCE

School Medication Administration Form 2020 -2021

ONE (1) MEDICATION PER FORM – REQUIRED FOR ALL (PRESCRIPTION & OVER THE COUNTER) MEDICATIONS

Student Name: _____ **Birth Date:** _____

Physician Portion

Medication Name: _____ **Concentration:** _____

Dose: _____ **Route:** _____ **Frequency:** _____

Indication or instructions for "as needed" med: _____

_____

Possible Side Effects: _____

For Emergency Medication- The student is capable, has been instructed of the proper use of this medication, and may self-carry / self-administer this medication: Yes No (Circle one)

Date: _____ **Physician Name:** _____

Physician Signature: _____ **Phone/Fax:** _____

Parent/Guardian Portion

I request this medication be given as prescribed (above) including on field trips. I release school personnel from any liability in the administration of this medication and understand that I am responsible for communication with the healthcare provider who is ordering this medication. I understand that this medication will not be administered by a school nurse. I understand that this authorization will be effective and need to be renewed each school year. I agree to provide medication in the unopened original container (for over the counter med) / with a printed label from the pharmacy (prescription med) and pick the medication up at the end of the school year. I will provide all necessary devices required to administer this medication, if needed (ie: nebulizer mask/tubing, syringes, pill crusher, medcup, etc). Information may be exchanged with staff working with my child, medical providers, and emergency personnel, if needed, to ensure the student's safety.

For Emergency Medication- The student is capable, has been instructed of the proper use of this medication, and may self-carry / self-administer this medication: Yes No (Circle one)

Date: _____ **Parent/Guardian Name:** _____

Parent/Guardian Signature: _____ **Phone:** _____