SCHOOL ADMINISTRATION OF MEDICATION

PLEASE RETURN THIS FORM TO THE SCHOOL NURSE.

Student Name____________________________ **Physician's Name**____________________________
Address____________________________ **Address**____________________________
____________________________ ____________________________
Student's School____________________________ **Number**____________________________
Student's DOB____________________________

This form must be filled out each school year for any student who is taking prescribed medication that must be administered during school hours and after school sponsored activities by school staff or under the supervision of school staff. This also applies to any prescription medication to be administered during school hours as needed for a life-threatening situation due to a severe allergy or chronic health condition. **Both physician and parents' signatures are required at the bottom of the form** if any changes in medication or dosage take place, a new form must be completed. **ALL MEDICATIONS MUST BE IN THE ORIGINAL CONTAINER**. This form adheres to WV State Board of Education Policy (2422-8): Medication Administration.

USE ONE FORM FOR EACH MEDICATION.

Medication:____________________________ **Diagnosis:**________________________

Dosage and Time:________________________ **Route/Method:**____________________

Possible Side Effects:____

Allergies &/or other instructions:____
For ASTHMA student: student to carry inhaler at all times? YES/NO
Student to self administer inhaler? YES/NO
For DIABETES student: student to carry Diabetes supplies at all times? YES/NO

FOR ANAPHYLACTIC REACTIONS TO:
Bee Sting________________ **Food Allergy**__________________________ **Other**____________

Medication: (please circle) IF NO IMPROVEMENT-ADMINISTER:

Benadryl 12.5 mg	Epi-Pen Injection IM
Benadryl 25 mg	Epi-Pen Jr. Injection IM
Benadryl 50 mg	Student to carry Epi-Pen at all times? YES/NO

Physician's Signature____________________________________ Date______________

Parental Signature Approving the Administration of above ordered Medication and Release of Liability

I, the parent/guardian of ______________________, enrolled at ____________________ realizing the importance of administering medication to my child as prescribed by the student's physician, do hereby agree to relieve designated school personnel of any liability from any potential ill effects as a result of their giving or injecting my child with the medicine prescribed by the child's physician. I have discussed this with my physician and realize its ramifications and thoroughly understand the meanings of these statements.

Parent/Guardian Signature_________________________________ Date______________

School Nurse Signature___________________________________ Date______________