



**Akron  
Children's  
Hospital**

**SCHOOL HEALTH SERVICES**

Attach  
Student  
Picture  
If available

**Prescription Medication Administered at School**

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: \_\_\_\_\_