453.4(F)

ERIN SCHOOL
Administering Medication to Student Form

Name of child ____

Date of Birth ________________________________ Grade/Teacher ________________________________

Name of Parent ______________________________ School ___________________________________

This is to certify that, in order to keep this child in optimum health and/or help maintain optimum performance at school, it is necessary that medication is given during school hours.

1. Medication (include trade name) ____

2. Reason for medication ____

3. This medication is to be given in the form which is circled: Tablet Ointment Capsule Inhalation Liquid

   Other (please specify) ____

4. Dosage (amount to be administered during school hours)____

5. How often during school hours or at what time(s) ____

6. Termination date of administering ___________________________________

7. If this medication is on a PRN (as needed) schedule, please describe how the person administering medication is to determine when the medication is needed: ____

____

8. Side effects (expected or predictable) ____

____

The child's parent/guardian knows of this request and is in full agreement that this medication will be administered as indicated. Should the student manifest any of the following symptoms caused by the medication, please discontinue administration and notify the parents or my office immediately.

9. Contraindications (*to state something to be inadvisable while taking particular medication because of a likely adverse reaction)* for administration of medication____

____

10. Check who should administrator medicine: __ Student __ Staff __ Parent

________________________________ ________________________________
Signature of Parent/Guardian Date

________________________________ ________________________________
Name of physician (please print) Physician Phone Number

________________________________ ________________________________
Physician's Signature Date

**One week after the last day of school, all remaining medication will be properly disposed of.