HMONG COLLEGE PREP ACADEMY

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School Medication Administration Form - 2017-2018

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

Student Name: ____ **Birth Date:** ______________________________

Prescriber 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 (*Check one*)

Date: ____________________ **Prescriber Name:** ____

Prescriber 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 (*Check one*)

Date: ____________________ **Parent/Guardian Name:** ____

Parent/Guardian Signature: ______________________________________ **Phone:** __________________________

Medication Receipt *To be completed by school personnel*

Student Name:____ Birth date: _________________

Medication: ___________________________ Count: _____ Parent Initials: _________ Date: ________

*Staff accepting medication:*______________________

AUG	SEPT	OCT	NOV	DEC	JAN	FEB	MAR	APR	MAY	JUN
1	1	1	1	1	1	1	1	1	1	1
2	2	2	2	2	2	2	2	2	2	2
3	3	3	3	3	3	3	3	3	3	3
4	4	4	4	4	4	4	4	4	4	4
5	5	5	5	5	5	5	5	5	5	5
6	6	6	6	6	6	6	6	6	6	6
7	7	7	7	7	7	7	7	7	7	7
8	8	8	8	8	8	8	8	8	8	8
9	9	9	9	9	9	9	9	9	9	9
10	10	10	10	10	10	10	10	10	10	10
11	11	11	11	11	11	11	11	11	11	11
12	12	12	12	12	12	12	12	12	12	12
13	13	13	13	13	13	13	13	13	13	13
14	14	14	14	14	14	14	14	14	14	14
15	15	15	15	15	15	15	15	15	15	15
16	16	16	16	16	16	16	16	16	16	16
17	17	17	17	17	17	17	17	17	17	17
18	18	18	18	18	18	18	18	18	18	18
19	19	19	19	19	19	19	19	19	19	19
20	20	20	20	20	20	20	20	20	20	20
21	21	21	21	21	21	21	21	21	21	21
22	22	22	22	22	22	22	22	22	22	22
23	23	23	23	23	23	23	23	23	23	23
24	24	24	24	24	24	24	24	24	24	24
25	25	25	25	25	25	25	25	25	25	25
26	26	26	26	26	26	26	26	26	26	26
27	27	27	27	27	27	27	27	27	27	27
28	28	28	28	28	28	28	28	28	28	28
29	29	29	29	29	29	29	29	29	29	29
30	30	30	30	30	30		30	30	30	30
31		31		31	31		31		31	

School staff administering medication will record time and initial as medication is give. Authorized Staff please print name and initial

1.____ 2.____

3.____ 4. ____