

**Englewood Schools**  
**Medication Administration in School or Child Care**

The parent/guardian of \_\_\_\_\_ *Child's Name* ask that school staff give the following medication \_\_\_\_\_ *Name of Medicine and Dosage* at \_\_\_\_\_ *Time(s)*

to my child, according to the Health Care Provider's signed instructions on the lower part of this form.

**Prescription medications** must come in a container labeled with: child's name, name of medicine, time medicine is meant to be given, dosage, date medicine is to be stopped, and licensed health care provider's name. Pharmacy name and phone number must also be included on the label. **Over the counter medication** must be labeled with child's name. Dosage must match the signed health care provider authorization, and medicine must be packaged in original container.

The School agrees to administer medication prescribed by a licensed health care provider with prescriptive authority. The parent agrees to pick up expired or unused medication within one week of notification by staff.

**By signing this document, I give permission for my child's health care provider to share information about the administration of this medication with the nurse or a school staff delegated to administer medication.**

\_\_\_\_\_  
*Parent/Legal Guardian Name*                      \_\_\_\_\_  
*Parent/Legal Guardian Signature*                      \_\_\_\_\_  
*Date*

\_\_\_\_\_  
*Work Phone*                      \_\_\_\_\_  
*Home Phone*

**Health Care Provider Authorization**

Child's Name: \_\_\_\_\_ Birthdate: \_\_\_\_\_

Medication: \_\_\_\_\_ Route: \_\_\_\_\_

Dosage: \_\_\_\_\_ To be given in a school at the following time(s): \_\_\_\_\_

If the medication is prn (as needed), please describe symptoms to administer the medication and intervals between dose:

Special Instructions: \_\_\_\_\_

Purpose of medication: \_\_\_\_\_

Side effects that need to be reported: \_\_\_\_\_

Starting Date: \_\_\_\_\_ Ending Date: \_\_\_\_\_

\_\_\_\_\_  
*Signature of Health Care Provider with Prescriptive Authority*                      \_\_\_\_\_  
*License Number*

\_\_\_\_\_  
*Print Name of Health Care Provider*                      \_\_\_\_\_  
*Phone Number*                      \_\_\_\_\_  
*Fax Number*

This student may carry their:  Inhaler  EpiPen  Other Medication (list) \_\_\_\_\_ to self medicate.  
This student has been instructed and is capable of self-administering the medication.

\_\_\_\_\_  
*Signature of Health Care Provider with Prescriptive Authority*                      \_\_\_\_\_  
*Date*

**I understand a written contract will be developed between the school nurse, the student and the parents/legal guardian to establish levels of responsibilities for each individual.**

\_\_\_\_\_  
*Parent/Legal Guardian's Name*                      \_\_\_\_\_  
*Parent/Legal Guardian's Signature*                      \_\_\_\_\_  
*Date*