THIS FORM MUST BE COMPLETED BY HEALTH CARE PROVIDER BEFORE ANY PRESCRIPTION MEDICATION CAN BE ADMINISTERED AT SCHOOL. PARENT/GUARDIAN SIGNATURES ARE REQUIRED BEFORE ANY MEDICATION MAY BE ADMINISTERED.

Missouri Laws allow the school nurse or other designated school personnel to assist students who are required to take medication during the school day. This service is provided to enable the student to remain in school to maintain or improve the potential for education and learning.

All medication must be in the container in which it was purchased. Prescription medication must have the pharmacy label attached, and must be currently prescribed for the student to whom it will be administered. Non-prescription medications (including over-the-counter medications) will be given at school only with current written instructions. *The first dose of medication is not to be administered by school personnel.* All medications must be kept in the school office to be administered by school personnel only.

Student name: _____ Date: _____
School of Attendance: _____ Grade: _____

FOR PRESCRIPTION MEDICATION: MUST BE COMPLETED BY HEALTH CARE PROVIDER:

Date student examined: _____
Diagnosis: _____
Medication Prescribed: _____
Dosage: _____ Time: _____ Route: _____
Side effects to note: _____
Medication administered until: _____(date)

It is necessary for this prescription medication to be taken during the school day at the time(s) indicated above and unlicensed trained school personnel may administer the medication.

Physician's Signature: _____
Physician's Name: _____ Date: _____
Address: _____ Phone: _____

I authorize school personnel to administer the above prescription medication to my child as ordered by the Health Care Provider. I also authorize the school to consult the Health Care Provider named above about my child's prescription medication need.

I authorize school personnel to administer non-prescription medication in the school office when I send written instructions.

Parent/Guardian Signature: _____
Printed or typed name: _____ Date: _____
Home Address: _____
Phone: Home _____ Work: _____

This form must be renewed whenever the prescription changes and at the beginning of each school year. The school reserves the right to reject requests for administering non-prescription medications.