

**Palmyra Eagle School District
Administering Medication to Students**

Must be completed for both prescription and non-prescription prior to administration

(Please return to your child's school)

Student Name _____

Physician's Name _____

Birth date _____ Male _____ Female _____

Physician's Address _____

School _____ Grade _____

Teacher (if applicable) _____

Physician's Phone _____

Parent/Guardian _____

Physician's Fax _____

Home Phone _____ Work Phone _____

Cell Phone _____

To Parent/Guardian/Physician:

The Palmyra Eagle School District is required by state statute to give prescription medication to students only with the complete directions from a physician and signed consent by parent/guardian. Medication must be supplied in the original container or packaging. For safety and liability reasons, medication received in any container other than the original will not be acceptable for staff administration. By signing this form, you release the Board of Education, its agents and employees from any and all liability which may result from taking this medication.

Start Date _____ End Date _____
Beginning of school year (BOSY) End of School Year (EOSY) = July 30

Medication _____ Dosage _____ Frequency _____

Medication Expiration Date (if applicable) _____

Form: Tablet/Capsule Liquid Inhaler Nebulizer Injection Other _____

For episodic/emergency events only. (Emergency medications such as: inhaler, glucagon, insulin, Epi-pen).

Student to self-administer/carry: Yes No

Time(s) to be given _____ Reason for this medication _____

If given on an "as needed" basis, please describe _____

Special instructions _____

Side effects (expected or predictable) _____

Physician's Signature _____ **Date** _____

(Signature required for all prescription medication and for non-prescription medication that exceeds the manufacturer's recommended dosage).

Parent/Guardian Signature _____ **Date** _____

(Signature required for all prescription and non-prescription medication).