Hutchinson Public and Parochial Schools - Health Services

Prescription Medication Form

School Year _____

Student _____ DOB _____ Grade/Room _____

To be completed by physician, health care provider, or authorized prescriber

Medication Name _____

Medication Dose _____

Medication Frequency/Instructions at School _____

Reason for medication _____

Start Date _____ Stop Date _____ ☐ Episodic/Emergencies Only

Physician/Provider Signature _____ Date _____

Printed Name _____ Clinic _____

Medication Name _____

Medication Dose _____

Medication Frequency/Instructions at School _____

Reason for medication _____

Start Date _____ Stop Date _____ ☐ Episodic/Emergencies Only

Physician/Provider Signature _____ Date _____

Printed Name _____ Clinic _____

Inhalers/epipens

This student can self-carry his/her inhaler or epipen

☐ Yes ☐ No

This student is both capable and responsible for self-administering this medication

☐ Yes, unsupervised ☐ Yes, supervised ☐ No

Blood glucose monitoring

This student requires blood glucose monitoring during the school day. Instructions include

_____

This student is both capable and responsible for self-glucose monitoring

☐ Yes, unsupervised ☐ Yes, supervised ☐ No

** I understand by signing this form, I authorize the school to administer the medication(s) according to standard school policy. I give permission for the LSN or building nurse to contact my child's health care provider regarding this plan and/or medication, and to communicate with my child's teachers, bus company, athletic director and/or other school personnel regarding my child's health condition(s) as deemed necessary. I release school personnel from liability in the event of adverse reactions resulting from this medication. I understand that administration of medication may not necessarily be done by a nurse. I authorize my child to self-administer his/her medication if deemed appropriate by LSN, parent and health care provider.*

Parent/Guardian Signature _____ Date _____ Received by _____