Harrisonville Cass R-IX Schools

Medication Administration Sheet

Student: ______________________ Grade: ________________

Class/Teacher: __________

Student's Medical Condition/Diagnosis: ________________________

Student's Physician and phone: ______________________________

Parents number: ____

Emergency Contact: ____________________________________

Medication: ________________________ Route: ___________

Dose: _____________ Duration: ____________________

RETURN DATE:

____

QUANTITY:

____

RECIPIENT:

X________________

NURSE:

X________________

COMMENTS:

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I give the school nurse (aand his or her trained personnel) my permission to administer the above medication to my child as the physician has ordered, or as directed on the over the counter medication label. I have read the Medication Policy and agree to adhere to the policy to ensure the safety and well being of my child. I also understand it is my responsibility to bring and pick up the medication and that I cannot send it with my child to school nor have my child bring it home. This ensures safety of all children within my child's environment. I will notify nurse, either by phone, note, or in person, if any changes to my childs medication regime needs to occur. I give the nursing staff permission to contact my child's physician for any information pertaining to my child's medication and/or medical condition. I give my child's physician permission to share any necessary medical information with the school nurse as well.

Parent Signature: ________________________________ Date: ________________

Nurse signature: ________________________________ Date:________________