Morgan County Schools Health Services **This form is valid for one year only.**

Physician's Form for Administration of Medication and Self Medication including Over-the-Counter Medication

The following is to be completed by a Licensed Health Care Provider (physician/nurse practitioner). No medication of any kind will be given to your child until this form is completed and returned to the school. Remember, **ALL** medication must be in a **pharmacy-labeled container or the original unopened bottle.** If any changes in medication occur during the school year, a new form must be completed, with a new pharmacy-labeled container and returned to the school.

- **Each medication requires a new form**.
- Medication must be brought to school by a responsible adult. Please **do not send** medication by children.
- **A Parent Signature is required before a student can be assisted with self-medication.**

TO BE COMPLETED BY PARENT/GUARDIAN: MY CHILD IS COMPETENT TO SELF-ADMINISTER THE MEDICATION WITH ASSISTANCE.

Student ____ Date of Birth ______________________

School ____Grade ______ Teacher ______________________

I give permission for my child to be assisted in taking the medicine described below by authorized persons.

Date _________________ Parent/Guardian Signature ____

Home Phone ___________________ Cell: _____________________ Work: _______________________

Emergency contact & Phone No. ____

TO BE COMPLETED BY PHYSICIAN:

Diagnosis for which this medication is given ____

Name of Medication ____Dosage ______________________

Route ___________________________________Frequency ____

If medication is given daily, at what time? __________________ A.M. _________________________P.M.

If medication is to be given "when needed" describe symptoms ______________________________________

How soon can it be repeated? __________________Is refrigeration necessary? ______________________

Possible side effects/procedure to follow ______________________________________ DC Date ________

Physician/Nurse Practitioner Name (Print) ____

Physician/Nurse Practitioner Signature ____

Address ____ **Zip** __________________

Phone ____ **Fax** __________________

Pharmacy ____ **Phone** ________________

School Staff: Complete Form Received __________________ By _____________________________________