

WEST CHESTER AREA SCHOOL DISTRICT
SCHOOL ADMINISTRATION OF MEDICATION

SCHOOL _____

STUDENT NAME _____ DOB _____ GRADE _____ HR _____

NAME PARENT/GUARDIAN _____

DIAGNOSES MEDICATION DOSAGE TIME ROUTE

POSSIBLE SIDE EFFECTS: (PLEASE CIRCLE)

ANOREXIA SEDATION AGITATION ANXIETY CONSTIPATION NAUSEA

VOMITING HEADACHE DRY EYE FATIGUE DIZZINESS DIARRHEA

OTHER _____

SPECIAL INSTRUCTIONS _____

ADMINISTER UNTIL: _____

MEDICATION/DRUG ALLERGIES: _____

ADDITIONAL PERTINENT INFORMATION _____

MAY MEDICATION LISTED ABOVE BE SKIPPED ON FIELD TRIP DAYS?
PLEASE CIRCLE- YES OR NO

PARENTS ARE ENCOURAGED TO ATTEND FIELD TRIPS TO GIVE ANY MEDICATIONS LISTED OTHER THAN EPIPENS OR INHALERS.

WILL PARENT BE ABLE TO ATTEND FIELD TRIPS TO GIVE THIS MEDICATION?
PLEASE CIRCLE- YES OR NO

I(WE) GRANT PERMISSION FOR THE SCHOOL NURSE TO COMMUNICATE WITH THE HEALTH CARE PROVIDER REGARDING MEDICATION CONCERNS!

HEALTH CARE PROVIDER (PRINT) _____ PHONE _____

HEALTH CARE PROVIDER SIGNATURE _____ DATE _____

PARENT/GUARDIAN SIGNATURE _____ DATE _____