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**_____

M-26 REV 6/08