Medication Administration Permission & Instructions Form

Required Medication Administration Instructions

(If more than two medications are required, please complete this form.)

Medication administration times are listed; if the student has a time-sensitive medication that falls outside of these designated times, please indicate below:

3. Medication Name:_____ Dose:_____

Reason/Diagnosis: _____

Medication Start Date:____/____/____ Stop Date: ____/____/____

Route: ☐ Oral ☐ Inhalation ☐ Buccal ☐ Topical ☐ Intramuscular ☐ Subcutaneous ☐ G-Tube Other:____

If DAILY, Time(s) to be given (Please Check All That Apply):

☐ Breakfast (8:30-9:00) ☐ Lunch (11:30-noon) ☐ Dinner (5:30-6:00) ☐ Before Bedtime (8:30-9: 15)

If, AS NEEDED, (PRN) Frequency: ☐ Every 4-6 hrs. ☐ Every 6-8 hrs. Other: _____

FOR INHALER or EPINEPHRINE AUTO-INJECTORS or other rescue medications approved by a physician only.

☐ Self-Carry (Student demonstrates competence) ☐ Stored in Health Center ☐ Other: _____

Other instructions or precautions-possible reactions: _____

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4. Medication Name:_____ Dose:_____

Reason/Diagnosis: _____

Medication Start Date:____/____/____ Stop Date:____/____/____

Route: ☐ Oral ☐ Inhalation ☐ Buccal ☐ Topical ☐ Intramuscular ☐ Subcutaneous ☐ G-Tube Other: ____

If DAILY, Time(s) to be given (Please Check All That Apply):

☐ Breakfast (8:30-9:00) ☐ Lunch (11:30-noon) ☐ Dinner (5:30-6:00) ☐ Before Bedtime (8:30-9: 15)

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☐ Self-Carry (Student demonstrates competence) ☐ Stored in Health Center ☐ Other: _____

Other instructions or precautions-possible reactions: _____

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5. Medication Name:_____ Dose:_____

Reason/Diagnosis: _____

Medication Start Date:____/____/____ Stop Date:____/____/____

Route: ☐ Oral ☐ Inhalation ☐ Buccal ☐ Topical ☐ Intramuscular ☐ Subcutaneous ☐ G-Tube Other:

If DAILY, Time(s) to be given (Please Check All That Apply):

☐ Breakfast (8:30-9:00) ☐ Lunch (11:30-noon) ☐ Dinner (5:30-6:00) ☐ Before Bedtime (8:30-9: 15)

If, AS NEEDED, (PRN) Frequency: ☐ Every 4-6 hrs. ☐ Every 6-8 hrs. Other: _____

FOR INHALER or EPINEPHRINE AUTO-INJECTORS or other rescue medications approved by a physician only.

☐ Self-Carry (Student demonstrates competence) ☐ Stored in Health Center ☐ Other: _____

Other instructions or precautions-possible reactions: _____

FOR PHYSICIAN USE ONLY:

I have reviewed and am directing the administration of the listed medications as indicated for _____

Physician/ Office Name	Physician's Signature	Date