Tarkio R-1 School District
Medication Administration Form

Student Name:_____ DOB:_____ Grade:_____

- All medications must be brought to the office by a parent or guardian and must be sent in the original labeled container.
- Nearly all medication can be given at home rather than at school (please administer medication at home when possible).

Type of medication (only **ONE** medication per form):

☐ Routine (daily) Administration
☐ As Needed Medication

Name of Medication:_____
Dose:_____ (Mg, Tsp, Tbsp, puffs, # of tabs)
Reason for Medication: _____

How medication is to be administered:
(please check one)

By mouth:_____ Topical Ointment:_____ Eye Drops:_____ Nebulizer:_____ Inhaler:_____
Times to be given at school:_____ **OR** frequency if given as needed:_____
The stop date of this medication is:_____ **OR** ☐ End of School Year
Is this medication a controlled substance? ☐ Yes ☐ No
I do want ☐ I do not want ☐ the mid-day dose of medication administered on early-release days

Prescribing Physician:_____ Phone:_____

I hereby release all trained school personnel from liability should a reaction occur that results from the proper administration of the medication. I understand that an additional parent/physician-signed statement will be necessary if the dosage of the medication is changed. I also authorize the school nurse to talk with the physician or pharmacist should a question come up about the medication.

All information on this form shall be kept confidential. However, if necessary, some medical information will be shared with other school staff to assist in maintaining your child's medical safety.

Parent/Guardian Signature:_____ Date:_____

Nurse Use Only:
Physician Order Obtained _____

Nurse Signature:_____ Date:_____