TEACHWELL SOLUTIONS

Medication Administration

PRESCRIPTION MEDICATIONS

Please have a physician confirm your child's medication needs

If your child needs to take prescription medication while at school, Teachwell Solutions needs this form completed at least once per year.

STUDENT AND FAMILY INFORMATION

A parent or guardian completes this section of the form.

STUDENT NAME

FIRST _____ LAST _____

SCHOOL PROGRAM

Please select

SELECT PROGRAM

DATE OF BIRTH

MM _____ DD _____ YY _____

PARENT OR GUARDIAN NAME

FIRST _____ LAST _____

PARENT OR GUARDIAN PHONE NUMBER

_____

AUTHORIZATION TO SELF-ADMINISTER EPI-PEN OR INHALER PRESCRIPTION

_____ INITIAL — I authorize personnel at Teachwell Solutions to administer prescription medication to my child.

_____ INITIAL — I understand that prescription medication must be provided in an original, properly labeled container.

_____ INITIAL — I relieve the school, its employees and any of its vendors of all responsibility related to the administration of medication.

_____ INITIAL — I give Teachwell Solutions employees and vendors have permission to communicate with my child's prescribing providers to ensure medication can be properly administered.

_____ INITIAL — I understand that prescription medications may only be stored at school during the time the prescription is authorized by a medical professional.

_____ INITIAL — I understand that unused medication will be discarded if not secured by a parent or guardian.

PARENT OR GUARDIAN SIGNATURE _____

DATE

MM _____ DD _____ YY _____

THIS FORM HAS ADDITIONAL PAGES → → → PLEASE CONTINUE → → →

STUDENT MEDICAL CARE INFORMATION (MEDICAL PROVIDER)

This section of the form should be completed by your child's healthcare provider.

PATIENT NAME | **DATE OF BIRTH**

FIRST | LAST | MIDDLE | MM | DD | YY

MEDICAL DIAGNOSIS

PRESCRIPTION MEDICATION | **DOSE**

TIME(S) TO BE ADMINISTERED AT SCHOOL | **METHOD OF ADMINISTRATION**

PRECAUTIONS AND REACTIONS TO OBSERVE

START DATE (MM DD YY) | **END DATE** (MM DD YY)

PHYSICIAN AUTHORIZATION AND SIGNATURE

PHYSICIAN SIGNATURE | MM | DD | YY

PHYSICIAN NAME (PRINTED) | CLINIC OR HOSPITAL NAME | PHONE NUMBER

SEND COMPELTED FORM TO:
email | karin.reisch@teachwell.org fax | 605-367-6036
Mailing Address | Teachwell Solutions – 715 East 14th Street, Sioux Falls, SD 57104