Alcoa City Schools
Prescribed Medication Form

Name DOB

PARENT TO COMPLETE

Parent Name Phone Number

Emergency Contact Phone Number

- ☐ I give permission for the medicines listed below to be administered in school by nurse or other trained staff as appropriate.
- ☐ I consent to communication between the prescribing healthcare provider or clinic, the school staff as needed for diagnosis and medication management.

Parent Signature Date

HEALTHCARE PROVIDER TO COMPLETE

Diagnosis

Name of Treating Provider Phone Number

Name of Office Fax number

Medications for diagnosis

MEDICAL PLAN

Name of medication to be given at school and dose

Time to administer medication Route of medication administration

Please list any anticipated side effects, restrictions or any additional notes below:

_____ (Healthcare provider initial **ONLY** if agree) This student is capable and responsible for carrying and self administering this medication.

Prescriber Signature Date

SCHOOL NURSE TO COMPLETE

Signature Date

Date medication form received