

City of Cape Coral Charter Schools Medication Administration Form



Student Name: _____ DOB: _____

Diagnosis: _____

Policy for the administration of over-the counter & prescription medication:

- > NO medication will be administered without an order by a licensed health care provider.
- > Medication must be in original package and labeled with student's name and dosage instructions.
- > Medication must be delivered to the school by parent/legal guardian.

Medication	Time to be given	Amount/dose	Beginning/ End dates

Medication should be administered during off-campus activities including field trips.

Licensed Health Care Provider Signature / Licensed Health Care Provider Name Date

Licensed Health Care Provider Phone Licensed Health Care Provider Fax

Parent/Legal Guardian Consent for Medication Administration:

I authorize the designated personnel of The City of Cape Coral Charter Schools to administer the medication regimen as listed above to my child/student. I authorize the school nurse and/or designee to exchange information with the prescribing health care provider in regards to the purpose, dosage, and effects of this medication.

Parent/Legal Guardian Name Date

Parent/Legal Guardian Signature