DISTRICT 2 - SKILLSUSA

MEDICATION ADMINISTRATION FORM

Student Name:______________________________ CTE School:_____________________

- All medication, both prescription and non-prescription, must be kept with the SkillsUSA District 2 nurse with the exception of Epi-Pens, inhalers, and insulin.
- All medication to be administered while on a SkillsUSA sponsored trip is required to be accompanied by a medication order from the prescribing healthcare provider.
- No medication shall be administered to any student without proper completion of this SkillsUSA District 2 Medication Administration Form.
- The term "medication" includes prescription drugs as well as over-the-counter medications, vitamins, and supplements.
- Completion of the form includes signatures of both the parent/guardian and healthcare provider.
- A separate form is needed for each medication and must include the dosage, time to be administered, and any other special instructions.
- All medication must be in the original, properly labeled prescription bottle or packaging.
- Only the necessary doses of medication needed for the duration of the trip or event should be sent with the student.
- All medications should be placed in a Ziploc bag clearly labeled with the student's name and school.

PLEASE CHECK IF THE STUDENT HAS ANY OF THE HEALTH CONDITIONS LISTED:

Asthma	Food Allergy (requiring ation)	Latex Allergy	Skin Allergy
Inhaler/Nebulizer	Hearing Problem	Vision Problem	Respiratory y/Problem
Diabetes	Heart Condition	Medication Allergy	Bee/Insect String ring medication)
Bleeding Disorder	Seizure Disorder	Other (please explain):	

Please explain any of the above checked conditions, or any other special health needs/accommodations you would like the SkillsUSA Nurse to be aware of: ____

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DISTRICT 2 - SKILLSUSA

MEDICATION ADMINISTRATION FORM

Student Name: ______________________________ CTE School: ________________________

THIS FORM IS REQUIRED FOR ANY STUDENT WHO WILL/MAY NEED MEDICATION

TO BE COMPLETED BY THE PARENT/GUARDIAN:
As parent/guardian of the above named student, I hereby request that the treatment described below be administered to my child and release the staff of SkillsUSA and it's employees from liability for any damages my child may suffer as a result of the request.

Signature of Parent/Guardian: _______________________________________ Date: _____________

Cell: ____________________________ Work: _______________________

TO BE COMPLETED BY THE HEALTHCARE PROVIDER:

Student's Age: ________ Grade: _________ School: ______________________________________

Name of Medication: ______________________________ Dosage: _____________ Time: ________

Special Considerations: ____

Reason for Medication: ________________________________ Effective Date: _______ to ________

I certify that I am the healthcare provider who prescribed the treatment, and that the above student is under my supervision as a patient.

Signature of Physician/Dentist: ____

Printed Name: ____

Address: ____

Phone: ___________________________________ Fax: __________________________________