EXCEL
ACADEMY CHARTER SCHOOLS

MEDICATIONS FORM

This form is required **ONLY** if your child takes prescribed medications during the school day

Excel Academy and state regulations require that the following form be on file in your child's health record before we begin to give any medication or make any medication-related accommodation at school. *Whenever possible, medications should be scheduled at times other than school hours.*

Medications must be delivered to the school in **a pharmacy or manufacturer-labeled container** by you (parent/guardian) or a responsible adult whom you designate. Please ask your pharmacy to provide separate bottles for school and home. **No more than a (30) thirty-day supply** of the medication should be delivered to the school nurse. Families are responsible for picking up any unused medications. All expired and unused medication will be discarded at the end of the school year.
Return completed form and medications to your child's School Nurse.

PARENT or GUARDIAN:

I request that my child ______________________________________receive _________________________ (Name of Medication) as

prescribed in the **ATTACHED ORDER (OR the form below)** by: _____________________________(*Name of Prescriber of Medication).*

Do you consent to your **child self-administering medication in the Health Office**? _____Yes _____No

(The ability of a student must first be assessed and authorized by the school nurse.)

Signature *of Parent or Guardian* ____

Parent/ Guardian Name: _____________________________Telephone Number: _____ _______________ Date: ________________

SIGNED MEDICATION ORDER - **PLEASE ATTACH a signed Medication Order** from the prescribing Health Care provider. **OR ask the health care provider to complete the section below.** This written medication order form may be taken to your child's primary care provider or other health care provider authorized to prescribe medications (e.g.,physician, nurse practitioner, etc.) for completion. **This form must be renewed and re-submitted to the SCHOOL NURSE with any new medications, changes to the current medications, and at the beginning of each school year.**

PHYSICIAN: - I request that my patient, ____, receive the following medication:

Medication 1	Medication 2
Diagnosis:	Diagnosis:
Name of medication:	Name of medication:
Prescribed dosage:	Prescribed dosage:
Time to be taken during school hours:	Time to be taken during school hours:
Expected duration of treatment:	Expected duration of treatment:
Possible side effects and adverse reactions:	Possible side effects and adverse reactions:
Other recommendations:	Other recommendations:

*Please complete another Medications Form for additional medications.

Print Name: ____Clinic: ____

Signature: ____Date: _____________________________________

Telephone #: ____Fax #: ____

(Updated for 2025-2026 School Year)

EXCEL
ACADEMY CHARTER SCHOOLS

FORMULARIO DE MEDICAMENTOS

Este formulario es necesario **SOLO** si su hijo(a) toma medicamentos recetados durante el día escolar

Excel Academy y las regulaciones estatales requieren que el siguiente formulario esté archivado en el registro de salud de su hijo(a) antes de que comencemos a administrar cualquier medicamento o hacer modificaciones relacionadas con el medicamento en la escuela. *Siempre que sea posible, los medicamentos deben programarse en horarios que no sean el horario escolar.*

Usted (padre/tutor) o un adulto responsable que usted designe debe entregar los medicamentos a la escuela **en una farmacia o en un recipiente con la etiqueta del fabricante.** Solicite a su farmacia que le proporcione frascos separados para la escuela y el hogar. **No se debe** entregar a la enfermera de la escuela un suministro del medicamento por **más de (30) treinta días**. Las familias son responsables de recoger los medicamentos no utilizados. Todos los medicamentos vencidos y no utilizados se desechan al final del año escolar. **Devuelva el formulario completo y los medicamentos a la enfermera escolar de su hijo.**

PADRE o TUTOR:

Solicito que mi hijo ______________________________________ reciba _________________ (nombre del medicamento) según lo prescrito en la ORDEN ADJUNTA O en el formulario a continuación por : ____ (Nombre de quien prescribe el medicamento)

¿Da su consentimiento para que su hijo se auto administre medicamentos en la Oficina de Salud? (por ejemplo, un inhalador)

_____ Sí _______ No (La capacidad de un estudiante primero debe ser evaluada y autorizada por la enfermera de la escuela).

Firma del padre o tutor ____

Nombre del padre/tutor: ______________________________ **Número de teléfono:** ___________________ **Fecha:** _______________

ORDEN DE MEDICAMENTO FIRMADA: ADJUNTE una Orden de medicamento firmada por el proveedor de atención médica que prescribe. O pídale al proveedor de atención médica que complete la sección a continuación. Este formulario escrito de orden de medicamentos puede entregarse al proveedor de atención primaria de su hijo o a otro proveedor de atención médica autorizado para recetar medicamentos (por ejemplo, médico, enfermera practicante, etc.) para que lo complete.

Este formulario debe renovarse y volverse a enviar a la ENFERMERA ESCOLAR con cualquier medicamento nuevo, cambios en los medicamentos actuales y al comienzo de cada año escolar.

PHYSICIAN: - I request that my patient, ____, receive the following medication:

Medication 1	Medication 2
Diagnosis:	Diagnosis:
Name of medication:	Name of medication:
Prescribed dosage:	Prescribed dosage:
Time to be taken during school hours:	Time to be taken during school hours:
Expected duration of treatment:	Expected duration of treatment:
Possible side effects and adverse reactions:	Possible side effects and adverse reactions:
Other recommendations:	Other recommendations:

*Please complete another Medications Form for additional medications.

Print Name: ____Clinic: ____

Signature: ____Date: ____

Telephone #: ____Fax #: ____

(Updated for 2025-2026 School Year)