# ANNAPOLIS AREA CHRISTIAN SCHOOL
# PARENT REQUEST TO ADMINISTER MEDICATION AT SCHOOL AND PHYSICIAN ORDER FORM

## PARENT'S REQUEST TO ADMINISTER MEDICATION AT SCHOOL

**FOR COMPLETION BY PARENT/GUARDIAN**

**Name of Student:** _____ **D.O.B:** _____/_____/_____
(LAST) (FIRST) (MI)

**Name of School:** _____ **Grade:** _____ **School Year:** _____

***In order for my child to receive medication in school, I agree to the following:***

* All prescription and non-prescription medication will have a physician's signed order **fully** completed for each school year.
* The prescription medication will be in a container labeled by the pharmacist or physician with:
  *Name of child* *Name of medication* *Dosage, route and time of administration*
  *Name of physician* *Prescription date and expiration date* *Conditions for proper storage*
* The non-prescription medication will be in the original sealed container with the label intact. Student's name will be put on the container in a position that does not obscure the label.
* The medication will be brought to school by an adult. Students are not to handle medications!
* The physician will be called if a question arises about my child's medication.
* The first dose of this medication (except for Epi-Pen) has been given without problems.

***Having read the above conditions, I request Annapolis Area Christian School personnel administer the medication as prescribed by the physician below. I certify that I have legal authority to consent to medical treatment for the student named above, including the administration of medication at school.***

**Signature of Parent/Guardian:** _____ **Date:** _____

**Relationship to student** _____

**Phone #: (H):** _____ **(W):** _____ **Other :** _____

**Address:** _____

## PHYSICIAN'S SIGNED ORDER FOR MEDICATION AT SCHOOL
## ONE MEDICATION PER FORM

**Diagnosis:** _____

**Name of medication:** _____

**Dosage:** _____ **(mg, ml, ml/tsp, # of puffs)**

**Route:** _____ **Time of Administration at School:** _____ ☐ **Lunchtime**

**If PRN, for what symptoms?** _____ **How often?** _____

**Please list any specific precautions personnel should be aware of or any unusual effects that might be observed.** _____

_____

**Services should begin (Date)** _____ _____ **and terminate (Date)** _____

FOR INHALER, EPI-PEN, and INSULIN ONLY:

_____**It has been determined that this student is able to self-administer and carry inhalant medication or Epi-pen and has been trained in its use including knowing when the medication is to be used.**

_____**It has been determined that this student is able to self-administer insulin.**

_____**This student should not self-administer inhalant medication, Epi-pen or insulin.**

**Physician's Signature:** _____ **Physician's Name (Printed):** _____
**(original, no stamp)**

**Address:** _____

**Telephone Number:** _____ **Date:** _____

☐ **Order Reviewed** _____ **R.N. Date** _____