**REQUEST FOR ADMINISTRATION OF MEDICATION AT SCHOOL**
**Grades 9-12**

Student's Name:_____ Date of Birth: _____
School:_____Grade:_____
Parent/Guardian Name:_____ Phone:_____Work:_____
Physician Name:_____ Phone:_____
Pharmacist Name:_____ Phone:_____
Medication: ***(Or generic/commercial equivalent)***_____
Dose:_____ Time to be given:_____
Period from:_____to:_____ Reason for Medication:_____
Expected Side Effects:_____
Additional Directions:_____

**PRESCRIPTION MEDICATION**

Your signature on this document attests to your willingness and intent to direct, supervise, decide, inspect and oversee the administration of the medication by non-medically trained designees, and that you will accept direct communications from them regarding the administration of the medication. We urge that all instructions be stated in layperson language. (Please use space provided above)

**Physician's signature:_____Date:_____Phone:_____**
**Parent/Guardian signature:_____Date:_____**

**NON-PRESCRIPTION MEDICATION**

I hereby give my permission for_____to receive the above named nonprescription medication at school as directed and supervised by the physician and/or parent/guardian. I understand that the school personnel are only the administrators of the medication as directed by the parents and physician and that the school cannot assume any responsibility or liability for any reaction or complication arising from administering the medication as directed.

**Parent/Guardian signature:_____Date:_____**

**SELF-ADMINISTRATION OF MEDICATIONS/INHALERS (excludes controlled substances)**

I hereby give_____permission to carry and self-administer the above medication. This student has been instructed in the proper use of this medication, and I believe s/he is sufficiently responsible to keep this medication in his/her possession and control its use.
The school office has been provided with a back-up inhaler: Yes__ No__
**Physician's signature**:_____**Date**:_____**Phone**:_____
**(required for prescription medication/inhaler only)
**Parent/Guardian signature**:_____**Date**:_____
**(required for non-prescription **and** prescription medication/inhaler)
**NOTE:** If it is determined at a later date that the student is not able to self-administer the medication, other arrangements will be made.

Ref: Stoughton Area School District Board Policy 1001.00 (Revised 3/99, 11/04, 8/07, 06/09, 8/13)