REQUEST FOR MEDICATION TO BE GIVEN DURING SCHOOL HOURS

This request must be signed by parent/guardian and physician to authorize medication during school hours

SCHOOL NAME: _____

TO BE COMPLETED BY PHYSICIAN:

Pupils Name: _____ Grade: _____ Diagnosis: _____

Medication: _____ Dosage: _____ Route: _____

Time to be given: _____ Purpose of medication: _____

Significant information: (include side effects and toxic reaction)

_____

_____

_____

Duration of order from _____ to _____

Yes No If medication is used for asthma/allergic reaction (ie: inhaler/epipen) I certify this student has been taught to self administer and should be allowed to carry own medicine and use as prescribed.

_____ _____ _____ _____

Telephone Physicians Name (please print) Physicians Signature Date

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TO BE COMPLETED BY PARENT OR GUARDIAN:

I request that my child be administered the medication as indicated in the physician's order above. I understand that non-medical personnel conduct the administration. If an emergency injection is ordered, I give permission for the School Nurse to instruct designated staff in the administration technique. I understand that it is my responsibility to furnish this medication within a container properly labeled by a pharmacist with identifying information, e.g., name of child, medication dispensed, dosage prescribed, and the time it is to be given and to transport the medication to school unless special arrangements are made.

I authorize the release and exchange of medical and educational information between my child's physician and school staff that is necessary in carrying out this service to my child.

Yes No If medication is inhaler or epipen I authorize my child to carry and administer own medication as prescribed by physician.

_____ _____ _____

Parent/Guardian Signature Telephone/Cell Date