REQUEST FOR ADMINISTRATION MEDICATION AT SCHOOL

School_____Grade/ Home Room_____

Name of Student_____DOB_____

PART 1: MEDICATION TO BE TAKEN AT SCHOOL – TO BE COMPLETED BY PHYSICIAN

The above mentioned student is under my care for (Diagnosis)_____

Name of Medication_____Doseage and Route_____Time_____

Administration to begin_____Administration to end_____

Is this medication being prescribed outside the formulary guideline?_____

List all other medication this child is taking_____

Severe adverse reaction to be reported to the physician_____

_____

Please list any medication allergies_____

Special instructions_____

Name of physician_____Address_____

Phone_____Emergency number_____

Physician's signature_____Date_____

PART 11: TO BE COMPLETED BY PARENT OR GUARDIAN AND RETURNED TO SCHOOL

I request that the above medication be administered to my child according to the instructions provided. I agree to deliver the medicine to the school in the container in which it was dispersed by the prescribing physician or licensed pharmacist. I grant permission for the school nurse to confer with the above licensed prescriber regarding my child's health and treatment issues as they pertain to the above medication/ diagnosis and his/her educational and behavioral management needs. If the above information changes, I will submit a revised statement signed by the physician.

** **Signature of parent/ guardian** _____Date_____

Address_____

Home Phone_____Work Phone_____Cell Phone_____

The school will supervise administration of medication in pill form. The school will assume responsibility for administering unit-dose liquid medication.

++Children who are in foster home placement by an agency that holds custody, the agency must sign.

PART 111: TO BE COMPLETED BY SCHOOL STAFF

Person(s) authorized to administer medication for this student. Principal should list names.

1)_____

2)_____

**Nurse Signature_____Date_____

***Principal's Signature_____Date_____

Dayton Early College Academy, Inc.

REQUEST FOR SELF-MEDICATION FOR ASTHMA INHALERS

School_____Grade/Home Room_____

Name of Student_____DOB_____

Address_____

Name of Medication/ Metered Dose Inhaler_____

Orders for use (# of puffs, frequency, with/without spacer_____

Administration start date_____Administration end date_____

Adverse reactions to report to prescribing practitioner_____

_____

Adverse reactions to watch for in unauthorized user_____

_____

Procedure to follow in the event the medication/ metered dose inhaler does not produce the expected relief from student's asthma attack_____

_____

Other instructions_____

By signing below the physician or other health care provider and parent/ guardian state that it is their request that the child carry the ordered inhaler on their person at school and at school functions; they realize that because the student is self-administering medication, no adult may be aware that the student is experiencing difficulty, preventing adults from responding appropriately in an emergency: and that the child has been fully trained in the use of the inhaler, knows why, how and when to use it properly and will not give the inhaler to any other student.

Prescriber's name_____Phone_____

Prescriber's signature_____Date_____

Parent/ Guardian name_____Phone: Work_____

Home_____

Parent/ Guardian signature_____

Other_____

Nurse's signature_____Date_____

Principal's signature_____Date_____