Yellow Springs Schools

Request for Assistance in the Self-Administration of NON-PRESCRIBED Medication

*** Some students are able to attend school only through the effective use of medication.
*** If possible, ALL medications should be given under the supervision of parent/guardian outside of school hours.
*** When medication is required during the school hours, school personnel may help administer prescibed medication when completed documentation of all information as requested from parent/guardian.
*** Medication is delivered to the school by parent/guardian in the ORIGINAL LABELED CONTAINER in which is was purchased. NO LOOSE pills, cough drops, etc.
***** Students who use medication on a DAILY basis, EXCEED label recommendations, indicate PROBLEMS with this medication, or for whom this medication in NOT INDICATED will require DOCUMENTATION FROM A PHYSICIAN/PRIMARY CARE PROVIDER.**

**** Name of medication - ONLY ONE Medication PER FORM!!!**

* Medication name
* Dose & frequency
* Route to take medication
* Reason for taking medication

Student Name	Grade / Teacher
Address	Allergies
Parent/Guardian Phone #:	Secondary Contact Phone #:

INFORMATION from PARENT/GUARDIAN:

The following medication needs to be administered DURING the SCHOOL HOURS and is being administered for that time. I understand that unlicensed school personnel may be assisting the child with the self-administration of this medication. This medication has already been administered to this child and there has been no untoward reaction to the medication. School personnel are not liable for effects related to the use of this medication.

NAME of medication (ONLY ONE medication PER form)	
DOSE of medication	
AMOUNT to be administered	
TIME or INTERVAL for medication	
ROUTE to be administered	
if PRN (as needed), give SPECIFIC indications & guidelines for medication	
ADVERSE REACTIONS to report to provider	

START date:	END date:

Parent / Guardian Authorization:
I request that the medication prescribed be administered to the student. I agree to submit in writing a revised prescriber statement in the event that any of the required information should change. I give permission for the principal and/or school nurse to contact the health care provider regarding the administration of this medication in the school setting. I agree to deliver the needed medication to the school in a timely manner and in the proper container as noted above. I agree to pick up any remaining medication within THREE days of the termination of administration and/or the end of the school year; if not, school staff will dispose of medication.

Parent/Guardian Name (print)	Signature:	Date:

SCHOOL USE ONLY

Request Accepted:
Request Denied/Reason:
Individual(s) Authorized to assist with medication administration:

Signature of Principle: Date:

Signature of School Nurse: Date:

- ☐ MEDICATION in Med Drawer
- ☐ FIELD TRIP list updated
- ☐ ANNUAL staff training
- ☐ DASL updates