Licensed Provider Request for Administration of Medication During School Hours

I, the undersigned licensed provider, request that the school nurse or other designated person administer the medication I have prescribed below. I certify that failure to administer the medication may jeopardize the health of my patient.

STUDENT NAME: _____DATE OF BIRTH: _____

ADDRESS: _____

PARENT/GUARDIAN: _____

PROVIDER NAME (PRINT CLEARLY): _____

PROVIDER ADDRESS: _____TELEPHONE: _____

DIAGNOSIS OF STUDENT: _____

NAME, DOSE, ROUTE OF PRESCRIBED MEDICATION(S): A separate prescription must be provided for school use only.

_____

_____

SPECIFIC TIME/CIRCUMSTANCE UNDER WHICH MEDICATION IS TO BE ADMINISTERED IN SCHOOL:

_____

POSSIBLE SIDE EFFECTS OF MEDICATION: _____

_____

FOR WHAT DURATION SHOULD THIS MEDICATION BE GIVEN? _____

IS THIS STUDENT TAKING ANY OTHER MEDICATION? Please list: _____

_____

_____

DO YOU WANT THIS STUDENT TO SELF-ADMINISTER HIS/HER OWN MEDICATION?
YES _____ NO _____ (Asthma inhalers and epi-pens only)

CURTAILMENT OF SCHOOL ACTIVITY? YES_____ NO _____
(Please specify: Sports, shop, lab, driver's training, gym, etc.)_____

PROVIDER SIGNATURE: _____DATE: _____

Please mail/fax this request to: Karen Nigrelli, MSN, BA, RN
Phone: 978-682-0260 x695
Fax: 978-683-5325
Knigrelli@centralcatholic.net