NORTHGATE SCHOOL DISTRICT

Request for Medication Administration in School

To be completed by Licensed Prescriber: Date:_____

Student's Name:_____ Grade/Homeroom:_____

Medication	#1	#2
Dosage		
Route		
Time of administration		
Length of administration	Start: Stop:	Start: Stop:
Reason for Medication		
Administration instructions		
Side effects		
Signature of Prescriber	Name_____ Date_____ (not valid without prescriber signature)	
FIELD TRIP	Please check the following option when a parent/guardian or parent/guardian designee (non-staff) is unable to attend a field trip: ____Yes, the prescribed dose can be withheld on the day of the field trip ____Yes, the time can be adjusted with the parent/guardian to be administered upon return to school ____No, this medication must be given to the child at the prescribed time Kindly explain:_____	
Competency for self-administration	I, _____, certify that this student has a potentially life threatening illness and requires an inhaler or auto-injecting epinephrine, and is a competent and has been instructed in the proper method of self-administration of said medication. The student may therefore carry and self-administer his/her inhaler and/ or auto-injecting epinephrine.	
Signature of Prescriber	Name:_____ Date:_____	

To be completed by Parent/Guardian:

I give permission for my child to receive the above noted medication at school according to the School Board Policy #210. I also give permission for the Certified School Nurse to contact the Licensed Prescriber, as necessary, regarding the medication.

Parent/Guardian Signature:_____ (not valid without signature)

TELEPHONE

Home_____ Cell_____

In the event of a two-hour delay opening:

____Yes, administer my child's medication as prescribed ____No, I will contact you if the time is to be adjusted

Permission to Carry and Self-Administer
Inhalers and Auto Injecting Epinephrine

I accordance with Pennsylvania State Law, hereby agree to allow my child to carry his/her asthma inhaler medication and auto injecting epinephrine. I acknowledge that the Northgate School District and its staff bear no responsibility for the benefits or consequences of the medication and that the school bears no responsibility for ensuring that the medication is taken. The Northgate School District reserves the right to withdraw permission at any time if the student is unable to demonstrate responsible behavior in carrying and/or taking this medication.

Parent/Guardian Signature:_____ Date:_____

I agree to be solely responsible for my inhalers and/or auto injecting epinephrine and to follow the directions for its use as ordered by my Licensed Prescriber and the District's medication policy. I am aware that any abuse of this privilege will result in confiscation of the medication and loss of privilege to carry and self-administer said medication. The student shall notify the School Nurse immediately following each use of an asthma inhaler and epinephrine auto-injector.

Student Signature:_____ Date:_____

For Health Office Use Only:

When a written statement of competency is not provided by the Licensed Prescriber: The student must meet all four criteria to carry and self-administer inhalers and/or auto-injecting epinephrines:

___1. Response and visually recognize his/her name
___2. Identify his/her medication
___3. Demonstrate proper technique for self-administering his/her medication
___4. Verbalize symptoms when medication should be used.

This student has demonstrated the ability to self-administer the said medication as indicated about.

Nurse's Signature:_____ Date:_____