

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 _____ School Year: _____

TO BE COMPLETED BY PHYSICIAN:

Pupils Name: _____ Grade: _____ Diagnosis: _____

Medication: _____ Dosage: _____ Route: _____

Time to be given: _____ am _____ pm 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 or diabetes (ie: inhaler,epipen,insulin) I certify this student has been taught to self-administer and should be allowed to carry own medicine and use as prescribed.

Physicians Name (please print) Physicians Signature Date Phone#

Physician and Parent please note per I-SS School Board Policy Code 6125 NO controlled substance (with the potential to impair student's ability to function at school ie: stay awake in class, potential for falling) shall be maintained or given by the school unless imperative to have for the student's education or for life threatening situation.

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 may conduct the administration or injection of medication after training by the school nurse. 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. Student will demonstrate to staff proper skill level for usage. 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, epipen, or insulin I authorize my child to carry and administer own medication as prescribed by Physician.

Parent/Guardian Signature Telephone/Cell Date

Reviewed by Nurse _____ Date _____