RTR PUBLIC SCHOOL SERVICES – SELF-ADMINSTRATION MEDICATION REQUEST FORM

Pupil's name: ______________________________ DOB ____________________

ADMINISTRATION OF ANY MEDICATION DURING THE SCHOOL DAY

Parents/guardians of pupils requesting that any medication be self-carried and/or self-administered during school hours by their child are requested to provide for the school a physician's order and parental release. Please have the following completed so the medication can be given safely correctly. Medication must be supplied in the original labeled container.

PHYSICIAN'S ORDER FOR SELF-CARRY AND/OR SELF ADMINISTRATION OF MEDICATION

I have prescribed the following medication for this student and request that dosages be given during

school hours: Medication: ______________________________ Dose: ______________ Route: __________

Frequency: __________________ Time(s): ____________________ PRN Repeat Frequency: ________________

For treatment of ______________________________ Possible side effects: ____________________________

Start date: ______________________________ Last date to be given: ______________________________

Other medications taken at this time: ____

Special Instructions: ____

____________________________________ Medication **ALLERGIES**: ______________________________

Self-carry: Yes_______ No______ Self-administer: Yes_______ No______

This student is capable of self-carrying and/or self-administering this medication and has received training on administering this medication as listed as well as the circumstances under which the medication may be given and the potential side effects of the medication.

Print physician's name: ____

Physician signature: ______________________________ Date: __________ Phone: __________

PARENTAL REQUEST/RELEASE FOR ADMINISTRATION OF MEDICATION

This authorization is given based on the following:

- My child is capable of and has been instructed in the proper method of self-administration of this medication.
- I understand the my child shall be permitted to carry at all times their medication as long as they do not endanger him/herself or other persons, and will not misuse the medication.
- I understand that if my child misuses by not taking the prescribed dosage, or endangers others with the medication, school employees or agents may confiscate the medication.
- I understand that this authorization shall be effective for this current school year and must be renewed annually.
- I give the Health Services Staff authority to communicate with the ordering physician about this medication.
- I release school personnel from any liability in the administration of this medication at school.

Parent/Guardian signature: ____

Date: ____________________ Home phone: ____________________ Work Phone: ____________

To promote safety for your child, medication information may be shared with school personnel working with your child and with 911 personnel, if they are called.