SPECIAL SSD SCHOOL DISTRICT
SPECIALIZED FOR SUCCESS

School Year: _____

PARENT/GUARDIAN REQUEST FOR ADMINISTRATION OF MEDICATION AT SCHOOL
HEALTH SERVICES

I request and give my permission for Special District Registered Nurses, or their designee, to administer the following medication(s) (listed below) to my child_____and to consult with my child's physician(s) _____at (phone)_____regarding any concern or questions in reference to the administration of medication during the _____/_____school year.

Please list each medication you are requesting your child be given <u>at school</u>

	Drug Name	Dose	Time
1.	_____	_____	_____
2.	_____	_____	_____
3.	_____	_____	_____
4.	_____	_____	_____
5.	_____	_____	_____

All medications to be administered at school must be given to the school nurse in a <u>current</u> pharmacy container labeled with the following information:

- Child's name
- Authorized provider's name
- Pharmacist's name and phone
- Prescription number.
- Date prescription filled
- Specific instructions for administering
- Name of medication

We will not administer any medication unless labeled as above. This may require that your child's authorized provider write two prescriptions (one for home use and one for school use) so the pharmacist can separate the medication into two labeled containers. Some pharmacies will provide you with a "school bottle".
Exception: Over the counter medication must be brought in an unopened bottle and be accompanied by a written prescription from the physician.

It is the parent's/guardian's responsibility to notify the school nurse when medication is changed and/or discontinued.

_____ _____
Parent/Guardian signature Date