Request for Administration of Medication at School

To be completed by parents/guardians of students with medical conditions requiring medication at school on an annual basis or if changes in medication occur.

A. To be completed by parent/guardian:

Name of Student:_____ Birthdate:_____

Name of Parents:_____

Mother:_____ Phone-Work:_____Home:_____

Father:_____ Phone-Work:_____Home:_____

Emergency Contact:_____ Phone:_____

Name of Physician:_____ Phone:_____

Describe the medical condition which requires medication to be taken within school hours:

_____

_____

_____

B. To be completed by prescribing physician. (This section may be completed by attaching a current pharmacy medical label.) Note: Parents would need to ask for an extra label and medication printout from Pharmacy.

Name of Medication:	Dosage:	Directions for use & Storage
1._____	_____	_____
2._____	_____	_____
3._____	_____	_____

Additional comments (possible reactions/side-effects/consequences of missed doses):

_____

_____

Signature of Physician:_____ Date:_____

The medication listed above is to be: □ administered by district staff

□ self-administered by student

The medication listed above is located: □ in a supply maintained in the school

□ on the person of the student

□ other:_____

C. To be completed by student's parent/guardian:

I request the school to give medication as prescribed on the front of this form to my child whose name I record below:

Name of child:_____ Birthdate:_____

I will provide the medication in the original labeled container with clear instructions for administration and replace when outdated. I will notify the school promptly of any change in medications.

Comments:_____

_____

_____

Signature of parent: _____ Date:_____

D. Each school staff member who is responsible for the administration or supervision of the medication must review the information on this form then sign and date below:

Name (Please print)	**Signature**	**Date**

E. Medical Alert conditions only

To be completed by Public Health Nurse after the completed request is returned to the school only when a specific Medical Alert Condition as outlined in policy is involved.

Comments:

_____

_____

_____

Physician's Signature: _____ Date: _____