REQUEST FOR ADMINISTRATION OF MEDICATION

Administration of medications will be permitted on school property only when medically necessary and under direct supervision of appropriate staff members. We request that doses of medication be given outside of school hours, whenever possible. We recognize that this is not always feasible and we will administer medications that must be given during school hours. Before any medication may be given in school, these guidelines must be followed:

1. The school must receive written orders from the physician/licensed nurse practitioner detailing the name of the drug, dosage, and frequency of the prescription medication to be taken, using the PHYSICIAN/LICENSED NURSE PRACTITIONER portion in the middle of this form. **Should a change in this information occur, a revised written physician's statement must be submitted prior to administering this prescription medication.**
2. The parent/guardian must complete the PARENT OR LEGAL GUARDIAN portion of this form at the bottom of the page prior to administering any medication. If non-prescription medication is to be administered, the parent/guardian must submit in writing the name, time, dosage, and frequency of the medication.
3. **All medication is to be brought to the school by the parent or legal guardian in the original container which is appropriately labeled by the pharmacist or the physician.**
4. If a parent or legal guardian is unable to deliver the medication to the school, it is required that he/she **CALL THE SCHOOL** in order to confirm that it is being delivered by the student with the completed form.

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PHYSICIAN/LICENSED NURSE PRACTITIONER - Must complete for all prescription medications:

NAME OF STUDENT ________________________________ **D.O.B.** ____________**Grade** _______
SCHOOL ______________________________**DIAGNOSIS**___________________________________
NAME OF MEDICATION ____
DOSAGE, FREQUENCY, AND INSTRUCTIONS ____
______

____
DATE OF ORDER _______________________ DURATION OF ORDER _________________________
SPECIAL INSTRUCTIONS FOR ADMINISTERING MEDICATION _______________________________
***__**Asthmatic Students in Grades 6-12:**__ Student is capable & responsible to carry/self-administer this medication. Yes _______ No _______ **(Physician must initial)**
__**Diabetic Students and Students with Epi-Pens ONLY:**__ Student is capable & responsible to carry/self-administer this medication. Yes _____ No _______ **(Physician must initial)**
ADVERSE REACTIONS WHICH SHOULD BE REPORTED TO THE DOCTOR ____________________
____
PHYSICIAN'S/LICENSED NURSE PRACTITIONER'S SIGNATURE _________________________ **Phone #:**______

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PARENT OR LEGAL GUARDIAN - Please complete and sign below.

I request that the designated school personnel give the above medication as ordered by the physician/licensed nurse practitioner and hold them harmless from any claims or liability. I authorize a representative of the school to release or exchange information regarding this medication/diagnosis with/to the above licensed prescriber.

I do _____ /do not _____ request that the designated school personnel give the above medication during field trips.

I do _____ /do not _____ request that the designated school personnel give the above medication on school days of early dismissal/late schedule.

Signature - Parent or Legal Guardian: ____
Address - Parent or Legal Guardian: ____
Date: ____________________ Daytime Phone Number: ____________________ (8/09)