

**REQUEST/PERMISSION TO ADMINISTER MEDICATION IN SCHOOL**

**No Medication (whether over the counter or prescribed) will be administered without this information.**

Student Name: \_\_\_\_\_ DOB: \_\_\_\_\_ School: \_\_\_\_\_ Grade: \_\_\_\_\_

Name of Medication: \_\_\_\_\_ Reason: \_\_\_\_\_

**Type of Medication:**

- Tablet/Capsule     Liquid     Inhaler     Injection     Nebulizer     Other

**Instructions during the School Day:**

Dose: \_\_\_\_\_ Time: \_\_\_\_\_ Frequency \_\_\_\_\_

- For episodic/emergency events only: \_\_\_\_\_

**Start:**  Date form received     Other date: \_\_\_\_\_    **Stop:**  End of school year     Other date: \_\_\_\_\_

**Special instructions/side effects:** \_\_\_\_\_

**Special storage requirements:**     None     Refrigerate     Other: \_\_\_\_\_

The administration of this medication during the school day is necessary for the student's health and attendance in school. It is recommended that the first dose of a newly prescribed medication be given at home. This student has the knowledge and skill to carry and self-administer this medication, if allowed by school policy.

- Yes     No

**Physician's Name:** \_\_\_\_\_ **Physician's Signature:** \_\_\_\_\_

**Phone Number:** \_\_\_\_\_ **Fax:** \_\_\_\_\_

**MEDICATION MUST BE BROUGHT TO SCHOOL IN THE ORIGINAL CONTAINER BY THE PARENT/GUARDIAN (pharmacy will provide an extra labeled container if needed)**

I request and give permission for the school nurse or other unlicensed trained school personnel to administer the above medication to my child. Information regarding this medication may be shared with the appropriate school personnel. **NOTE:** Any changes to the information above shall require a new Request/Permission form.

**Permission to Contact Prescribing Physician:** I understand and agree that if the school nurse has questions regarding the physician's order, I give my permission for the school nurse to contact my child's physician and obtain additional information about the medication, administration schedule, and the effects of the medication on my child's learning. I consent to the physician providing that information.

**Medication Removal: I understand that I must pick up any medication no longer required or remaining at the end of the school year or it will be appropriately discarded.**

My child may carry and self-administer this medication if allowed by school policy.     Yes     No

Parent or Legal Guardian's Signature: \_\_\_\_\_ Date: \_\_\_\_\_

Home Phone: \_\_\_\_\_

Work: \_\_\_\_\_

Cell: \_\_\_\_\_

**To Be completed by School Nurse:**

This student demonstrates the knowledge and skill to carry and self-administer this medication.     Yes     No

School Nurse Signature: \_\_\_\_\_ Date: \_\_\_\_\_

Adopted: December 8, 2010; Rescinded & Moved to Administrative Procedure: October 25, 2017