ADMINISTRATION OF PRESCRIPTION MEDICATION REQUEST

Requests for school personnel to assist in administration of medications require that this statement be filed with the school office.

STUDENT INFORMATION

To be completed by parent/guardian:

Student Name: _____
Last First Middle

Birthdate: _____ School: _____ Teacher: _____

PARENT/GUARDIAN STATEMENT

During school hours and away from school for school activities, the principal, assistant principal, secretary, clerk, teacher, teacher assistant, guidance counselor, or nurse has my permission to assist in administering the medication prescribed and communicate with the physician when deemed necessary. I assume full responsibility for any side effects and complications my child may have as a result of taking this medication.

Medication needs to be transported to school by parent or responsible adult.

I understanding that all medication(s) provided to the school for use must be labeled by the pharmacist and that any changes must be reported by resubmitting this form with the school principal.

_____ _____
Parent/Guardian Signature Date

_____ _____
Home Phone Number Work Phone Number

PHYSICIAN STATEMENT

To be completed by the physician:

Name of Drug: _____

Dosage and times at school: _____

Estimated Termination Date: _____

For the Treatment of: _____

Side Effects (adverse reactions) which should be reported to the physician: _____

For Inhaled Medications:

[ ] I (name) _____ have instructed _____ in the proper way to use his/her inhaled medications. It is my professional opinion that _____ should be allowed to carry and use that medication by him/herself.

[ ] It is my (name) _____ professional opinion that _____ should carry his/her inhaled medications and receive assistance with administration.

_____ _____
Physician Signature Date

_____ _____
Print or type name of physician Phone

Address: _____

_____