Administration of Prescription Medication *2023-2024*

Parent/Guardians of students requesting that any prescription medication be administered during school hours by school staff are requested to provide for the school:

1. the **physician's order**. 2. a **parental release**, and 3. medication supplied in the **original container**.

Student Name: _____ Expiration Date: _____

Birthdate: _____ Grade: _____ Teacher/Advisor: _____

PHYSICIAN ORDER FOR ADMINISTRATION OF MEDICATION BY SCHOOL PERSONNEL

PHYSICIAN MUST FILL OUT **OR ATTACH A HARD COPY OF PHYSICIAN ORDER WHICH INCLUDES PHYSICIAN SIGNATURE*

I have prescribed the following medication for this student and request that dosages be given during school hours:

Medication: _____ Dose: _____ Route: _____

Time: _____ PRN Repeat Frequency: _____

(Morning medication dose _____mg to be given at school, if student forgets to take it at home.)

For treatment of: _____Possible side effects: _____

Special Instructions: _____ Last date to be given: _____

Other medications taken at this time: _____

Medication Allergies: _____

Print Physician's Name: _____ Phone: (_____)_____

Physician Signature: _____ Date: _____

PARENTAL REQUEST FOR ADMINISTRATION OF PRESCRIBED MEDICATION

I request this medication be given as prescribed. I release school personnel from any liability in the administration of this medication at school. I understand that I am responsible for communications with the ordering health care providers about this medication. I understand that this medication will not be administered by a licensed school nurse.

Please check appropriate spaces below:

____Keep this medication in school ____Send this medication home each evening

Physician and I agree that this student needs medication on field trips. ___Yes ___No
I feel my child should carry and self-administer his inhaler. ___Yes ___No ___ N/A
I feel my child should carry and self-administer his epinephrine (Epi-Pen) ____Yes ____No ___ N/A

Parent/Guardian Signature: _____ Date: _____
Home Phone: _____ Work Phone: _____ Cell Phone: _____

To promote safety for your child, medication information may be shared with school personnel working with your child and with 911 personnel, if they are called.

Administration of *Over-the-Counter* Medication *2023-2024*

Student Name: _____

Birth Date: _____ Grade: ____ Advisor/Teacher: _____

Parents/Guardians of students request for Administration of OTC medication:

I request that my child be allowed to take:

Name of OTC medication: _____

Dose: _____ Time/frequency: _____

Reason for medication: _____

This medication will not be used to mask symptoms of illness. If your child requests this medication for another reason than indicated, a staff member will call you for permission.

You will need to supply an unopened bottle of the requested OTC medication with your child's first and last name on it.

Print Parent/Legal Guardian Name: _____

Parent/Legal Guardian Signature: _____

Home Phone: _____ Work Phone: _____

Cell Phone: _____ Other Phone: _____

To promote safety for your child, medication information may be shared with school personnel working with your child and with 911 personnel, if they are called.