Administration of Medication in School
2020-2021

*** PRESCRIPTION MEDICATION**

Dear Parent or Guardian,

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

**PLEASE HAVE PHYSICIAN FILL OUT OR ATTACH A HARD COPY OF PHYSICIAN ORDER*

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, only 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 medication will not be administered by a 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

I feel my child should carry and self-administer his epinephrine (Epi-Pen) ☐ Yes ☐ No

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 Medication in School
2020-2021

*** OVER-THE-COUNTER MEDICATION**

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 person will call you for a verbal order.

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.