REQUEST FOR ADMINISTRATION OF MEDICATION AT SCHOOL

Student Name_____ Birth Date _____

School: _____ Teacher: _____Grade: _____

TO BE COMPLETED BY AUTHORIZED HEALTH CARE PROVIDER	
MEDICATION 1	**MEDICATION 2**
Medication name: _____	Medication name: _____
Reason for Medication:_____	Reason for Medication:_____
Dose: _____	Dose: _____
Method of Administration:_____	Method of Administration:_____
Time of Administration:_____	Time of Administration:_____
Start: ☐ Immediate ☐ Other Date:_____	Start: ☐ Immediate ☐ Other Date:_____
Stop: ☐ End of Year ☐ Other Date/Duration _____	Stop: ☐ End of Year ☐ Other Date/Duration _____
☐ For Episodic/emergency events only	☐ For Episodic/emergency events only
Restriction and/or important side effects: ☐ None anticipated	Restriction and/or important side effects: ☐ None anticipated
☐ Yes. Please describe:_____ _____	☐ Yes. Please describe:_____ _____
Special Storage Requirements ☐ Refrigerate ☐ None	Special Storage Requirements ☐ Refrigerate ☐ None

Health Care Provider's Signature: _____ Date_____

Address: _____ Phone _____

PARENTAL CONSENT FOR MEDICATION TO BE ADMINISTERED BY SCHOOL PERSONNEL

In authorizing designated school personnel to administer medication to my child in accordance with the physician's statement above, I agree to release the District, its officers, agents and employees for any loss, damage, injury or liability of any kind to any person caused or arising from acts, omissions or negligence of the District, its officers, agents and employees involved in the administration of medication to my child.

Parent(s) / guardian(s) of _____, request that medicine be administered by the school nurse or a member of the school staff if the school nurse is not available. I consent to allow disclosure of identifiable health information from the health care provider to the school nurse or other designated school personnel. I will notify the school if the medication has changed or is no longer needed. ***Medication will be furnished in its pharmacy-labeled container and personally delivered to school personnel.*** I understand that this medication will be destroyed if it is not claimed within one week following the termination of the physician's authorization or one week beyond the end of the school year.

Parent/Guardian: _____ Date: _____

Address: _____ Day Time Phone #: _____

Date of Receipt: _____ School Nurse Signature: _____

(**This request MUST be updated annually**.)

6/11