REQUEST FOR IN-SCHOOL ADMINISTRATION OF PRESCRIPTION MEDICATION
(One request form is to be completed for **each** medication prescribed)

Clinic personnel are **not** permitted to administer prescription medication of any kind unless the physician requests in writing that there is a need for such administration of medication during school hours. The doctor's statement **must** be accompanied by written permission of at least one parent and signed by the doctor.

In order to help maintain optimum health and maximum school performance it is necessary that the following medication be administered during school hours.

STUDENT'S NAME: ____DATE OF BIRTH: _____________
(MM/DD/YY)

NAME OF MEDICATION TO BE ADMINISTERED: ________________________________

REASON IT IS TO BE GIVEN: ____
FORM OF MEDICATION TO BE ADMINISTERED:

□ Tablet □ Capsule □ Liquid □ Inhalation

□ Other (Please specify): ____

INDICATIONS & DOSAGE: ____
(How often, how many, what time, etc.)

DATE MEDICATION IS TO BE DISCONTINUED: _________________________________

******Permission for the Self-Administration and Carrying of Asthma Medication or other REQUIRED Self-Carry/Self-Administered medications by the student ONLY (all other medications **MUST** be administered in the school clinic).

Name of medication to be administered: ________________________Symptoms which this medication is to be given____ Dose________________

Frequency ________________Maximum # of doses @ school ___________________
For Asthma medication: Peak flow readings_________

Beginning date _____________ Ending date _______________

Student may carry this medication. Yes _____ No ______

This child is capable of self-administration of this medication while on school property or school related events or activities. This means the prescription medication may be used at the student's discretion. Yes_____ No________

______________________________ ______________________________________
PHYSICIAN'S SIGNATURE PHYSICIAN'S PHONE NUMBER

____
DATE

AGREEMENT

I agree to hold the school harmless for the proper administration of medication provided by the parent(s)/guardian(s) and for any adverse drug reaction and/or side effects.

I agree to be responsible for maintaining an adequate supply of medication at the school in order to meet my child's needs.

______________________________ ______________________________
Parent/Guardian(s) Signature Date

______________________________ ______________________________
Cell Phone Number Home Phone Number