

### PARENT'S REQUEST TO ADMINISTER MEDICATION IN SCHOOL

Dear Parent/Legal Guardian:

To request medication administration at school, please note:

This form must be completed and signed by you and your child's medical provider.

- A new form is needed for all changes in medication, dose, or time.
- The medication should be brought to school by a parent/guardian or responsible adult.
- The medication container must be labeled by the pharmacy with the student's name, prescriber's name, name of medication, dosage, route, conditions for storage, prescription date, and expiration date.
- Unless otherwise specified, medication order is valid for the entire school year.
- Expired and discontinued medication not picked up by the last day of school will be destroyed.

### HEALTH CARE PROVIDER'S INSTRUCTIONS FOR GIVING MEDICATION IN SCHOOL

Name of Student: \_\_\_\_\_ Date of Birth: \_\_\_\_\_ Grade: \_\_\_\_\_

Condition for which medication is being administered: \_\_\_\_\_

Medication Name: \_\_\_\_\_ Dose: \_\_\_\_\_ Route: \_\_\_\_\_

Time/Frequency of administration: \_\_\_\_\_ If PRN, frequency: \_\_\_\_\_

If PRN, for what symptoms: \_\_\_\_\_

Special/Emergency Instructions: \_\_\_\_\_

Prescriber's Name/Title: \_\_\_\_\_ Telephone: \_\_\_\_\_

Address: \_\_\_\_\_ Fax: \_\_\_\_\_

Prescriber's Signature: \_\_\_\_\_ Date: \_\_\_\_\_  
(Original signature or signature stamp ONLY)

### AUTHORIZATION FOR STUDENT TO CARRY EPINEPHRINE AUTO-INJECTOR AND/OR INHALER

Prescriber Authorization \_\_\_\_\_  
Signature \_\_\_\_\_ Date \_\_\_\_\_

Parent/Guardian Authorization \_\_\_\_\_  
Signature \_\_\_\_\_ Date \_\_\_\_\_

### PARENT/GUARDIAN AUTHORIZATION

I/We request designated school personnel to administer the medication as prescribed by the above prescriber. I/We certify that I/We have legal authority to consent to medical treatment for the student named above, including the administration of medication at school. (I/We understand that at the end of the school year, an adult must pick up the medication, otherwise it will be discarded.) I/We authorize the school nurse to communicate with the health care provider.

Parent/Guardian Signature: \_\_\_\_\_ Date: \_\_\_\_\_

Home Phone #: \_\_\_\_\_ Cell Phone #: \_\_\_\_\_ Work Phone #: \_\_\_\_\_

FOR ALTERED SCHOOL SCHEDULES, THE FOLLOWING MEDICATION GUIDELINES WILL APPLY UNLESS YOU INDICATE OTHERWISE IN WRITING :

- One hour late opening: doses will be given as usual, with minor modifications in timing, if needed.
- Two hour late opening: medications scheduled to be given before 10 a.m. will not be given in school; other doses will be given according to the prescribed schedule.
- Three hour early dismissal: medications scheduled to be given at lunchtime or later will not be given.

### TO BE COMPLETED BY SCHOOL

Date form received at school: \_\_\_\_\_ Received by: \_\_\_\_\_