REQUEST FOR ADMINISTRATION OF MEDICATION AT SCHOOL

Student Name: _____ Birth Date: _____

School: Dan Savage M.S. 552-3300 FAX 552-3305 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: _____ Start: □ Immediate □ Other Date: _____ Stop: □ End of Year □ Other Date: _____	Time of Administration: _____ Start: □ Immediate □ Other Date: _____ Stop: □ End of Year □ Other Date: _____
□ For Episodic/emergency events only	□ For Episodic/emergency events only
Restriction and/or important side effects: □ None anticipated □ Yes. Please describe: _____ Special Storage Requirements □ Refrigerate □ None	Restriction and/or important side effects: □ None anticipated □ Yes. Please describe: _____ Special Storage Requirements □ Refrigerate □ None
ONLY for Epi-Pen or Metered Dose Inhaler: *This student is both capable and responsible for self-administering auto-injectable epinephrine or inhaled asthma medication:* □Yes □No □ Unsupervised □ Supervised This student may carry medication *(only if OK "unsupervised")*: □Yes □ No Please indicate any additional information: _____	***ONLY for Epi-Pen or Metered Dose Inhaler:*** *This student is both capable and responsible for self-administering auto-injectable epinephrine or inhaled asthma medication:* □Yes □No □ Unsupervised □ Supervised This student may carry medication *(only if OK "unsupervised")*: □Yes □ No Please indicate any additional information: _____

Health Care Provider's Signature: _____ Date: _____

Address: _____ Phone #: _____

PARENT/GUARDIAN 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 kid 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 Signature: _____ Date: _____

Address: _____ Daytime Phone #: _____

ONLY for Epi-Pen or Metered Dose Inhaler:
I hereby consent for my child to self-administer the following medication during the regular school day or when attending school-related activities.
Please note: The school nurse may at his/her discretion determine that the student is not able to safely carry and self-administer an Epi-Pen or inhaler, and may at his/her discretion have the student's medication held in the health office for school personnel to administer.

Parent/Guardian Signature: _____ Date: _____

School Nurse Signature: _____ Date of Receipt: _____

(This request MUST be updated annually.)

9/14