

Request for Administering Prescribed Medications by School Personnel

STUDENT NAME: _____ BIRTHDATE _____

GRADE: _____ TEACHER _____

NAME OF MEDICATION: _____ EXP. DATE: _____

DOSAGE: _____ TIMES TO BE GIVEN (SCHOOL HOURS): _____

REASON FOR MEDICATION: _____ QUANTITY GIVEN TO SCHOOL: _____

DURATION OF THERAPY (CIRCLE): 2020/2021 SCHOOL YEAR 5 7 10 OR 30 DAYS FROM FORM DATE

OTHER DURATION- START DATE: _____ END DATE: _____

1. Written authorization is required to **discontinue** prescription medication.
2. Prescription inhalant medication may be carried by the student ONLY if directed in writing by the Physician and Parent. (Complete form for Asthma Inhalers at School.)
3. Medication will be dispensed during school hour only.
4. CONTROLLED SUBSTANCES MAY ONLY BE RECEIVED BY A SCHOOL NURSE OR DESIGNATED PERSONELL.

Parent Consent: I consent to and authorize the health care provider to disclose health information to the school, and for the school to disclose the above information to those within the school district who have a need to know for legitimate educational purposes.

I understand that medications are to be dispensed during school hours only.

PARENT/LEGAL GUARDIAN SIGNATURE: _____ DATE: _____

Home/Cell phone: _____ Work phone: _____

NOTE: PLEASE INDICATE BELOW YOUR PREFERENCE FOR DISPOSITON OF ANY UN-USED PORTION OF YOU CHILD'S MEDICATION.

_____ Parent will pick up medication (PARENT MUST PICK UP CONTROLLED SUBSTANCE)

_____ Send medication home with student

OFFICE USE

Date Medication Received: _____ Quantity Received: _____ Received by: _____

Refill Date: _____ Quantity: _____ Received by: _____ From: _____

Refill Date: _____ Quantity: _____ Received by: _____ From: _____

Refill Date: _____ Quantity: _____ Received by: _____ From: _____

Refill Date: _____ Quantity: _____ Received by: _____ From: _____