GreatHearts Irving

Request for Administering Prescribed Medications by School Personnel

STUDENT NAME_____ STUDENT#_____ BIRTHDATE_____

SCHOOL Great Hearts Irving TEACHER_____

NAME OF MEDICATION,_____ Exp. Date_____

PHARMACY NAME & PRESCRIPTION NUMBER_____

DOSAGE_____

TIME TO BE GIVEN AT SCHOOL (DURING SCHOOL HOURS)_____

DATE MEDICATION STARTS._____ DATE MEDICATION ENDS_____

Reason for giving medication: _____

_____

1. Written authorization is required to ***discontinue*** prescription medication.
2. Prescription Inhalant medication may be carried by the student If directed In writing by the Physician and Parent. (Use form for Asthma Inhalers at School)
3. Medication will be dispensed during school hours only.

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.

Medications will be dispensed during school hours only.

Home Phone No. _____ _____
PARENT/LEGAL GUARDIAN SIGNATURE

Work Phone No._____ _____
DATE

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

_____PARENT WILL PICK UP MEDICATION
_____SEND MEDICATION HOME WITH STUDENT

Office Use

Date Medication Received

Quantity received

Initial & Date _____

Sent Home date: _____ Quantity sent: _____ Sent with: _____

Refill date: _____ Quantity received:_____ Received from:_____

Refill date: _____ Quantity received:_____ Received from:_____

Refill date: _____ Quantity received:_____ Received from:_____