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School Year:_____

REQUEST FOR ADMINISTERING PRESCRIBED MEDICATION AT SCHOOL

Student Name:	Date of Birth:
Grade/Section:	Teacher (lower school only):

PLEASE NOTE:

NAME OF MEDICATION:		Expiration Date:	
DOSAGE:		TIMES TO BE GIVEN (clinic hours 0800-1500)	
DURATION:	Entire School Year *(until directed otherwise)* Other duration:		
REASON FOR MEDICATION:			
QUANTITY GIVEN TO SCHOOL			
Current weight:			
Medication Allergies:			
Any additional information?			

1. Written authorization is required to ***discontinue*** prescription medication.
2. Medication will be dispensed during clinic hours only.
3. CONTROLLED SUBSTANCES MAY ONLY BE RECEIVED BY A SCHOOL NURSE OR DESIGNATED PERSONNEL.

CONSENT

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 clinic hours only.

In the absence of the school nurse, prescribed or physician approved OTC medications will be administered by a designated trained faculty/staff member.

PARENT/GUARDIAN SIGNATURE:		DATE:	
PARENT CELL PHONE *(or best daytime number):*			

NOTE: PLEASE INDICATE BELOW YOUR PREFERENCE FOR DISPOSITON OF ANY UNUSED PORTION OF YOUR CHILD'S MEDICATION.

- ❑ Parent will pick up unused medication.
- ❑ Please send home unused medication with student.

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CLINIC USE ONLY

Date received:	Quantity Received:	Total amount:	RN Signature:	Parent/ Guardian Signature:

Sent Home Date:_____ Quantity Sent Home: _____

Sent Home With: _____

Nurse Signature: _____

Controlled substances/Epi pens and Seizure medications need to be dropped off and picked up by a parent/legal guardian and my not be send home with the student.