Parent/Guardian and Authorized Health Care Provider Request for the Administration of Medication - Prescription and Nonprescription

To the Parent/Guardian:
Medications both prescription and over the counter are rarely given at school; the only exceptions involve special or serious problems where it deemed absolutely necessary by the physician that the medication be given during school hours. The parent is urged, with the help of your child's physician, to work out a schedule of giving medication at home, outside school hours whenever possible.

IF MEDICATION IS TO BE ADMINISTERED AT SCHOOL, ALL OF THE FOLLOWING CONDITIONS MUST BE MET

1. A signed request from a licensed physician/dentist specifying the condition for which the medication is to be given, the name, dosage, route, side effect and specific instructions for emergency treatment must be on file at school. School staff is not authorized to determine when an "as needed" medication is to be given. Specific instructions are necessary.
2. A signed request from the parent/guardian must be on file at school.
3. Medication must be in your child's original, labeled pharmacy container written in English.
4. All liquid medication must be accompanied by an appropriate measuring device.
5. A separate form is required for each medication.

Part A - Parent / guardian consent (to be completed by parent)

Name of Child: _____

I _____(parent) request that medication be administered to my child in accordance with our authorized health care provider written instructions. I understand that non-medical school personnel will administer medication. I will notify the school immediately and submit a new form if there are changes in medication, dosage and/or the prescribing authorized health care provider.

Parent Signature: _____

Part B - Authorized Health Care Providers Instructions (to be completed by physician)

Reason for Medication: _____ Name of Medication: _____

Medication is administered between 12:00 and 12:30 only.

Dose: _____ Route: _____

Potential side effects and expected response: _____

Actions to be taken in the event of side effects or incomplete treatment response. This includes actions to be taken in an emergency: _____

_____

Instructions for proper storage of the medication: _____

NOTE: This request is valid for a maximum of 30 days or whenever there is a change in medication, dose or route. The parent(s) and physician must complete a new form.

Date of request: _____ Date to discontinue medication: _____

Authorized Health Care Provider Signature: _____

Doctors' office stamp

For staff use only

This form must be reviewed and approved by the director prior to medication being administered.

Name of Child: ____

This form expires on: _______________
Please return this form to the office with any unused medication after this date.

Director's initials **_____________**

Caregivers: Write the date and time medication was given. Sign with your complete signature in the boxes below.

Date	Signature	Notes