

## Request for Administration of Medication

*To be completed by prescribing Health Care Provider*

Student's Name \_\_\_\_\_ Date of Birth \_\_\_\_\_

School \_\_\_\_\_ Teacher \_\_\_\_\_ Grade \_\_\_\_\_

Condition for which medication is being administered \_\_\_\_\_

Please administer to the student named above the following medication:

Name of Medication \_\_\_\_\_

Dosage \_\_\_\_\_ Route \_\_\_\_\_

Time to be given\* \_\_\_\_\_

\*If as needed, state frequency/for what symptoms \_\_\_\_\_

Relevant side effects:  None expected  Specify: \_\_\_\_\_

Please also complete this portion for *inhalers and emergency medications* that should be kept with student:

Possession and Self-Administration of Emergency Medication Authorization/Approval

According to IC 20-33-8-13, a student with a chronic disease or medical condition may possess and self-administer emergency medication for the chronic disease or medical condition if parent and physician authorization is given.

- Parent to complete:

Parent/Guardian authorization for  possession and/or  self-administration:

\_\_\_\_\_  
Parent Signature

\_\_\_\_\_  
Date

- Prescriber to complete:

The nature of the disease or medical condition may require emergency administration of the medication.  Yes  No

The student has been instructed in how to self-administer this medication.  Yes  No

Prescriber authorization for  possession and/or  self-administration:

\_\_\_\_\_  
Prescriber Signature

\_\_\_\_\_  
Date

For Emergency Meds

- It is understood that the medication is to be furnished to the school by the parent or guardian on a daily dosage basis. Over-the-counter medication must be provided in its original container. Prescription medication is to be furnished in a pharmacy-labeled container that matches the medication orders above.
- By signing, I give permission for the school nurse and prescribing health care provider to exchange information regarding any necessary medication order clarifications, response to medication, and adverse effects.
- Unless other arrangements are made, I give the school permission to send home medication that has been in its possession with my child at the end of the school year.

\_\_\_\_\_  
Parent or Guardian's Signature

\_\_\_\_\_  
Date

\_\_\_\_\_  
Doctor's Printed Name

\_\_\_\_\_  
Doctor's Phone Number

\_\_\_\_\_  
Doctor's Fax Number

\_\_\_\_\_  
Doctor's Signature

\_\_\_\_\_  
Date

**THIS FORM MUST BE RENEWED AT THE BEGINNING OF EACH SCHOOL YEAR**