

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

- It is understood that school policy requires parent/guardian to furnish medication on a daily dosage basis or parent/guardian/trusted adult to bring medication to school on a weekly basis upon nurse/principal approval. Over-the-counter medication must be provided in its original container. Prescription medication must 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

Prescriber's Printed Name

Prescriber's Phone Number

Prescriber's Fax Number

Prescriber's Signature

Date

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