Student Name: _____

REQUEST FOR ADMINISTRATION OF MEDICATION AT SCHOOL

Request must be completed prior to medications being at school.

The following section is to be completed by the PARENT/GUARDIAN

Student Name _____ Grade____ DOB ___/____/_____

Name of Medication_____

Reason for taking it: _____

Name of Physician _____ Physician Phone _____

I request and authorize George Stone School to administer the identified medication to the above-named student in accordance with the health care provider's prescribed instruction, not to exceed the current school year. I understand that the medication is to be furnished by me in the original container. For self-administration of inhaler or epi-pen, I authorize my child to carry and self-administer medication as specified. I understand that unlicensed staff may be assigned to provide medication to my student. I accept ultimate responsibility for monitoring the effects of this medication. I shall release/hold harmless and indemnify the George Stone School/Union College officers, employees, and agents against any and all claims, judgments or liabilities arriving out of the school-administered or self-administered medication as described.

Parent/Guardian _____ Date_____

Phone_____

The following section is to be completed by PHYSICSIAN/HEALTH CARE PROVIDER

Diagnosis for which medication is given _____

Name of medication _____

Mode of administration _____Dosage_____ Time of day_____

Effective dates _____ (Not exceed the current school year)

List significant side effects _____

Emergency procedure in case of serious side effect _____

Other information _____

☐ Yes* ☐ No For inhalers – Student is capable of carrying and self-administration.

☐ Yes* ☐ No For Epi-pen/Epi-pen Junior – Student is capable of carrying and self-administration

*Checking yes indicates student has been instructed in the purpose/method and frequency of use.

I request and authorize that the above named student be administered the above identified medication in accordance with the instruction indicated. Medication orders are good for the current school year, unless a shorter period is specified. There exists a valid health reason which makes administration of the medication advisable during school hours or during such time that the student is under the supervision of school officials.

Health Care Provider's Signature _____

Health Care Provider's Printed Name _____

Date_____ Phone_____ FAX _____