

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 PHYSICIAN/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 \_\_\_\_\_