

REQUEST FOR ASSISTED SELF-ADMINISTRATION OF MEDICATIONS

PRESCRIPTION and NON-PRESCRIPTION

Requests for a student to administer his / her own medication during school hours require that this statement be filed with the school principal. Please respond to every item on this form. If the medication is non-prescription, the parent fills out health care provider part.

School: _____ School Hours: _____ Teacher: _____

STUDENT INFORMATION

Student Name: _____ Date of Birth: _____

Address: _____ Phone: _____

Diagnosis (Optional): _____

HEALTH CARE PROVIDER STATEMENT

The health care provider may be a medical doctor (M.D.), dentist (D.D.S.), physician assistant (P.A.), or a registered nurse practitioner / clinician (R.N., C.S.).

To be completed by health care provider (If non-prescription medication, parent must fill out):

Name of Drug: _____

Date to Start: _____ Date to End: _____

Dosage and Times at School: _____

Does this medication absolutely need to be administered during school hours? yes no
If yes, please explain: _____

Special instructions for Storage and Handling:

Possible Side Effects:

Health Care Provider Name: _____ Phone: _____

Address: _____

Health Care Provider Signature: _____ Date: _____
(for prescription medication)

Parent Signature: _____ Date: _____
(for non-prescription medication)

STUDENT AND PARENT STATEMENTS

I take full responsibility for taking my own medication during school hours as prescribed by my health care provider. Medicine bottles will have the proper pharmacy label. If it is a non-prescription medication, it will be in the original container.

Student Signature: _____ Date: _____

I give consent for my child, _____, to take his / her own medicine during the school day, assisted by school personnel as necessary. My child is competent to self-administer the medication with assistance: yes no (Check one)

Parent / Guardian Signature: _____ Date: _____

Phone Number (in case of emergency): _____

*Only fully completed forms will be honored.