



**REQUEST FOR ADMINISTRATION OF
MEDICATION AT SCHOOL FORM**
Policy #325

A. TO BE COMPLETED BY PARENT OR GUARDIAN

Name	Birthdate (Year, Month, Day)	
Parent or Guardian	Home Phone	Business Phone
Physician	Phone	

PARENT/GUARDIAN: Attach a duplicate pharmacy label for medication that has been previously prescribed and for which there are no changes in the prescription information last provided on a "Request for Administration of Medication at School Form".

B. TO BE COMPLETED BY PRESCRIBING PHYSICIAN FOR NEW OR CHANGED PRESCRIPTIONS

Conditions Which Make Medication Necessary

If prescribing Epinephrine emergency medication, it must be a single dose, single-use auto-injector for a school setting. If parent/guardian has supplied a second injector, it can be given 10 - 15 minutes after the first, if symptoms have not improved or if symptoms recur. An oral antihistamine will not be administered by school personnel.

Name of Medication	Dosage	Directions for Use
1.		
2.		
3.		
4.		

Additional Comments (possible Reactions, Consequences of Missing Medication, Etc.)

<p>_____</p> <p>Physician's Signature</p> <p>_____</p> <p>Date</p>
--

