MEDICATION ADMINISTRATION FORM (RETURN TO SCHOOL NURSE)

REQUEST FROM PARENTS/GUARDIANS TO HAVE MEDICATION ADMINISTERED IN SCHOOL

Name of Student _____ Date _____

Medication _____

Dosage _____

Time _____

Direction for Administration _____

_____

For Middle and Upper School Only

My patient, _____, requires (inhaler, Epi Pen/Auvi-Q, insulin). I hereby give permission for her to carry this medication on her person in school (yes/no) and/or self administer (yes/no).

My patient, _____, is independent with the self administration of her above indicated emergency medication (yes/no).

I, _____, parent/guardian of the above named student, am aware that with permission to self carry emergency medications, comes a responsibility to make sure that my daughter always has her medication/supplies on her person and that the medications are plentiful and not expired.

I, _____, parent/guardian of above named student, will forward additional medication to be housed in the Health Center (yes/no).

_____ _____

Parent/Guardian Signature Physician Signature

_____ _____

Parent/Guardian Phone Number Physician Phone Number