Community Health Network

Request to Administer Medication to
STUDENT DURING THE SCHOOL DAY
2017-2018

If it becomes necessary for a student to take medication or receive treatment during the school day, the parent or guardian must complete this request form and file it in the school nurse's office. If the medication or treatment is physician-prescribed, the parent or guardian must submit a written prescription from the child's physician or the current pharmacy label with the request. A physician's order is also necessary for prescription samples that may have been released to student, or for any over-the-counter medication that is not recommended for children under age twelve.

All other over-the-counter medication must be in the original container labeled with the student's name and date of birth. Label instructions will be followed for all over-the-counter medicine unless otherwise prescribed by a physician.

This request is in effect for one school year and must be renewed annually or whenever there is a change in medication.

Parent's or Guardian's Authorization

I request that the medication described below be administered to my child/ward at the times specified during the school day. I will give the nurse the medication in its original container or current prescription bottle.

I understand that a parent or guardian will transport all medication to and from school for grades K-8. Medications must be picked up by the last day of school, or medications will be discarded.

☐ I give my permission for my child in grades 9-12 to bring home any unused medication.

I understand that a separate form must be completed for each medication.

I understand that this medication will be administered to my child only by authorized staff members and will be kept in a secure location within the school nurse clinic.

_____ Student's Name (Please Print)

Student's Date of Birth: _____/_____/_____ Month Day Year

_____ Name of Medication

Prescribed_____ Over-the-Counter_____

_____ Days Medication to be given

Times(s) to administer: _____a.m. _____p.m.

_____ Amount of Medication to be given

Lot # or Rx #_____

_____ Purpose of Medication

Refrigeration Required? Yes_____ No _____

_____ Signature of Parent or Guardian

_____ Date

_____ Printed Name

_____/_____/_____ Phone: Home / Cell / Work