

SCHOOL HEALTH SERVICES

REQUEST FOR ADMINISTRATION OF MEDICATION OR USE OF SUCTION, OXYGEN OR OTHER EQUIPMENT IN SCHOOL

(PLEASE SEE MESSAGE TO PHYSICIAN AND PARENT ON BACK OF FORM)

PHYSICIAN, PLEASE NOTE: Fill in all of the spaces. Missing information will cause the form to be returned to you. This will cause a delay in your patient receiving medication / treatment. A separate request is needed for each medication.

NAME OF PATIENT/STUDENT	ADDRESS/ZIP	ROOM/BOOK NO.
DATE OF BIRTH	SCHOOL/ORG.#	REGIONAL OFFICE
DIAGNOSIS:		PID

REASON MEDICATION MUST BE GIVEN IN SCHOOL:

NAME OF MEDICATION/EQUIPMENT/TREATMENT: _____ DOSE: _____

TIME(S) TO BE GIVEN IN SCHOOL: _____ TOTAL DOSAGE PER 24 HRS: _____

DATE BEGIN: _____ DATE END: _____

INSTRUCTION FOR ADMINISTRATION/UTILIZATION:

CONTRAINDICATIONS:

SIDE EFFECTS:

TREATMENT OF SIDE EFFECTS/ACTION TO BE TAKEN:

IS ANY RESTRICTION ON ACTIVITY NECESSARY: YES NO

IF YES, DESCRIBE: _____

IS STUDENT TAKING ANY OTHER MEDICATION? YES NO

IF YES, NAME OF MEDICATIONS: _____

IS SIMILAR EQUIPMENT KEPT BY THE CHILD'S FAMILY AT HOME? YES NO

PRINT NAME OF HEALTH CARE PROVIDER/CREDENTIALS _____ TELEPHONE _____

ADDRESS _____ EMERGENCY NUMBER _____

SIGNATURE OF HEALTH CARE PROVIDER _____ DATE SIGNED _____

I

To The Principal

I authorize selected school personnel to administer the indicated medication, or to use the equipment or machinery as prescribed by my child's health care provider, whose signature appears on this form.

My child may self-administer medication/equipment as determined appropriate by the school nurse.

I authorize the school nurse to communicate with my child's health care provider, and my health care provider to reply, as needed regarding this medication/equipment and/or my child's response.

PARENT SIGNATURE _____ TELEPHONE NUMBER _____

DATE SIGNED _____ EMERGENCY NUMBER _____



II

IN ACCORDANCE WITH CURRENT SCHOOL DISTRICT PROCEDURE, THE ADMINISTRATION OF THIS MEDICATION WAS APPROVED ON

DATE _____

(RETAIN IN SCHOOL)

SIGNATURE OF SCHOOL NURSE _____

TELEPHONE NUMBER OF SCHOOL NURSE _____