

REQUEST FOR SELF ADMINISTRATION OF MEDICATION AT SCHOOL

· · · · · · · · · · · · · · · · · · ·	School Year:	Year:	
Name:	School:		
Grade:	Teacher:		
Medication:	Dosage:	Reason:	
Time to Be Given:	 AM _ PM (or 🗖 As Needed	
From (Date)	To (Da	te)	
Prescriber's Name:		Prescriber's Phone #:	
Known Drug or Food Allergy to:			
the patient name, name be in the original packag A signed physician's stat medicine, whether it is p diagnosed anaphylaxis ir inhaler devices. In these recommendation. Student misuse of medical theirs available. This request is for the cultivation. I hereby request and give my content in the provider's directions.	of medication, dosage, and ing, with all directions, do ement indicating the necessorescription or over-the-concluding auto-injectable epercases the student's name tation being self-administeration is advised to be kept in the concluder of the carries request includes authoring the school of the carries request includes authoring the carries request authoring the carries reque	ntainer as prepared by a pharmacist and labeled, included time to be given. An over-the-counter medication is bages, compound contents, and proportions clearly messity must accompany and request for self-administration unter medicine except in the case of medication for binephrine and breathing disorders requiring handheld e on the prescription label is sufficient for the physicial ered may result in seizure and disciplinary action. In the health office in the event your child does not have and self-administer the above medication according ization for the school nurse to contact the health care nurse immediately in writing of any change in medication	must narked. ition of d an's ave
Parent/Guardian Signature:		Date:	
(Not recommendation of the commendation of the	equired for auto-injectable on or sign the statement be s the purpose, appropriate	is knowledgeable about the medication frequency, and has demonstrated the correct use of the prescribed medication on his/her person to self-adr	the
Signature of Health Provider:		Date:	