Drought School
Medication Administration Request Form

Student Name: _____ **DOB:**_____

Grade:_____ **School:**_____ **Allergies:**_____

Parent / Guardian Authorization:

I, the parent/guardian of the above named student, have read the school's medication policy & request the medication listed below to be administered to my child at school. I understand that I am responsible for bringing the medication to school in its original, updated, properly labeled container and for picking up any unused medication by the 2nd business day after classes conclude for the current school year **(all medications will be disposed of after this time - no medications will be sent home with a student).** I understand that a qualified, designated person will be administering the medication & that I am responsible for maintaining a sufficient quantity at school to avoid interruptions with the MD orders. I understand that if my child refuses a prescription drug, force will not be exerted by school personnel to make them comply. I will notify the school immediately if there is a change or cancellation of the medication. The school district has my permission to contact the prescriber in regard to medications that are prescribed.

Parent / Guardian Signature: _____ **Date:**_____

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NON-PRESCRIPTION (OVER-THE-COUNTER) MEDICATION PORTION: (MD signature NOT required)

Medication: _____ Dosage: _____ Frequency: _____

Time: _____ Route: _____ Reason: _____ Start Date: _____ End Date: _____

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PRESCRIPTION MEDICATION PORTION ONLY: (To be completed by a MD / PA /NPAP Only)

Medication & Dosage: _____ Amt: _____ Time: _____

Route: _____ Reason: _____ Side Effects: _____

Student _____CAN _____CANNOT carry & self-administer the prescribed rescue inhaler

Student _____CAN _____ CANNOT carry & self-administer the prescribed Epi-pen

Student _____ CAN _____ CANNOT carry the prescribed Glucagon

EMERGENCY MEDICATION MANAGEMENT (Asthma Inhalers / Epi-Pens / Glucagon) :

Medical Provider Signature: _____ Date: _____

Address: _____ Phone: _____