

NORTHWEST LOCAL SCHOOL DISTRICT

ADMINISTRATION OF MEDICATION (Physician's Order and Parental Permission)

SCHOOL: _____

School policy requires a written order from a licensed prescriber and consent of the parent/legal guardian before school personnel can give any prescribed or over-the-counter medication to a student. Please complete this form and return to the school office.

Name of Student _____ DOB _____ Grade _____ Homeroom _____

ID # _____

Address _____ Telephone _____

Allergies _____

Diagnosis/condition for which medication is administered _____

Name of medication, dose and route _____

Time or indication for administration _____

Specific instructions for administration _____

Possible side effects to be noted/reported _____

Effective Date _____ Expiration date of this order _____

(A new medication order must be submitted each school year)

For ASTHMA INHALERS, EPI-PENS, AND INSULIN PUMPS: In my opinion, this student shows the knowledge, understanding and ability to self-administer and be responsible for carrying the above medication during the school day. **YES** _____ **NO** _____

Instructions to follow in the event medication does not produce expected relief _____

Licensed Prescriber Signature

Print Name

____/____/____
Date

Phone Number

PARENT/GUARDIAN MUST COMPLETE:

I give permission for the principal or his/her designee to administer the medication as prescribed above to my child, and further agree to the following:

1. Submit to school personnel a revised order, signed by the licensed prescriber of the above, when any change in the original order occurs.
2. Submit to school personnel a written statement when medication has been discontinued.
3. Grant **permission for the school nurse to confer with the above licensed prescriber** regarding my child's health and treatment issues as they pertain to the above medication/diagnosis and his/her educational and behavioral management needs.
4. Cooperate with school personnel in assisting my child comply with medication administration instructions.
5. Bring all medications to school in the original container from the pharmacist.

For ASTHMA INHALERS, EPI-PENS, AND INSULIN PUMPS: It is my opinion that my child understands the use of this medication, including the condition and symptoms for which this medication is prescribed. My child demonstrates proper administration technique and has shown responsible behavior when it comes to carrying this medication. I further understand that my child may be asked to describe the symptoms for which this medication is prescribed and demonstrate proper administration technique to the nurse/health assistant in his/her school building. My child will be responsible for the medication that he or she carries during the school day.

_____ **Yes** _____ **No** _____ **Parent/Guardian Initials**

Parent/Guardian Signature

____/____/____
Date

Daytime Phone Number