

Medication Request/Consent Form

Medications are to be administered at home whenever possible. If it is necessary for a student to receive medication at school, all portions of this form must be completed before medication can be given at school.

One form for EACH medication is required.

Name of Student: _____ Birthdate: _____ Date: _____

School (circle one): Lower Elementary (K-4) Upper Elementary (5/6) Jr. High High School Grade: _____

Physician Name: _____ Phone: _____

MEDICATION:

- Name of Medication: _____
- Diagnosis: _____
- RX# (if applicable): _____
- Dose at School: _____
- Time to be given at school: _____
 - If as needed (PRN), reason for giving: _____
- Dates to be given (circle one): Entire School Year or From: _____ To: _____
- Precautions, if any: _____

INHALERS AND EPI PENS:

Lower and Upper Elementary/Jr. High Students:

- **ASTHMA INHALER:**
 - This student is capable of self-administration and may carry inhaler and self-administer at school. Circle one: Yes No
 - All inhalers must have Student's Name on the medication
- **EPI PENS:**
 - Allergy to: _____
 - Please provide two Epi pens
 - EPI Pens will be administered by school personnel
 - Please provide in original packaging with Student Name on the Pen and be sure medication is not expired

High School Students:

- **ASTHMA INHALERS:**
 - This student is capable of self-administration and may carry inhaler and self-administer at school. Circle one: Yes No
 - All inhalers must have Student Name on the medication
- **EPI PENS:**
 - Allergy to: _____
 - Please provide two Epi pens with the Student's Name on them
 - One EpiPen for the student to carry; and one to be delivered to the medication storage area at school

PARENT/GUARDIAN CONSENT:

- I request and authorize that school personnel administer this medication at school.
- I will supply medication in its original, current (not expired), properly labeled container. (Request extra bottle from pharmacist.)
- This order is in effect for this school year unless otherwise indicated.
- I will obtain a new physician's order and notify the school in writing of any changes.
- I further understand that all medication is to be transported to and from school by parent/guardian.
- I understand that non-medically trained school personnel may give medication.
- I agree to hold the School District, its employees, and agents who are acting within the scope of their duties, harmless in all claims arising from the administration of this medication at school.
- My signature indicates that I have fully read and understand the above information.

Signature of Parent/Legal Guardian _____ Phone _____ Date _____