**Eagle Valley Public Schools Health Services –**

**Administration of Medication during the School Day**

**Eagle Valley Public Schools Health Services** Expires: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Pupils Name: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_DOB\_\_\_\_\_\_\_\_\_\_\_\_School:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_Grade:\_\_\_\_\_\_

**ADMINISTRATION OF MEDICATION DURING THE SCHOOL DAY**

Parents of pupils requesting that **any** medication be administered during school hours by school staff are requested to provide for the school:

1. The **Physician’s Order**
2. A **parental release**, and
3. Medication supplied in the **original container.**

Ask your pharmacy for prescription medication to be divided in two bottles completely labeled – one for home and one for school.

**PHYSICIAN’S ORDER FOR ADMINISTRATION OF MEDICATION BY SCHOOL PERSONNEL**

I have prescribed the following medication for this student and request that doses be given during school hours: Medication:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Dose:\_\_\_\_\_\_\_\_\_ Route:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Time:\_\_\_\_\_\_\_\_\_\_\_\_\_\_ PRN Repeat Frequency\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

(Morning medication dose \_\_\_\_mg. To be given at school, **only** if student forgets to take it at home.)

For treatment of: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_Possible Side effects: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Special Instructions: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_Last date to be given: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Other medications taken at this time: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_Medication **ALLERGIES**: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Print Physician’s Name: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Physician’s Signature: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Date: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Phone: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**PARENTAL REQUEST FOR ADMINISTRATION OF MEDICATION**

I request this mediation be given as prescribed and I give the Health Services Staff authority to communicate with the ordering physician about this medication. I release school personnel from any liability in the administration of this medication at school. **I understand that medication will not necessarily be administered by a school nurse.**

***Please check the appropriate spaces below:***

\_\_\_\_\_\_Keep this medication at school \_\_\_\_\_\_\_\_ Send this medication home each evening

 Physician and I agree that this student needs medication on field trips. Yes \_\_\_\_\_\_\_ No \_\_\_\_\_\_\_\_

 I feel my child/adolescent should carry and self-administer his/her inhaler. Yes\_\_\_\_\_\_\_ No\_\_\_\_\_\_

Parent/Guardian Signature: \_\_ \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_Date:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Home Phone: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_Work Phone:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Cell Phone:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

*To promote safety for your child, medication information may be shared with school personnel working with your child and with 911 personnel, if they are called.*