

## ADMINISTERING MEDICINES TO STUDENTS

### Authorization for Dispensing Medication

Note: Whenever possible, medication should be given at home and every effort should be made to avoid school hours.

### To be completed by Parent or Guardian:

I request that my child, \_\_\_\_\_ grade \_\_\_\_\_ receives the medication as prescribed by our physician in the form below. The medication is to be furnished by me as required by Board policy. I understand that the school nurse or other designated adult will administer the medication. I further understand that the district and its employees assume no liability in the dispensing of the prescribed medication. I also agree to submit a revised statement signed by the physician if previously provided information changes.

Signature (Parent or Guardian) \_\_\_\_\_ Phone # (Home) \_\_\_\_\_  
Address \_\_\_\_\_ (Work) \_\_\_\_\_  
School \_\_\_\_\_ Homeroom Teacher \_\_\_\_\_ Date \_\_\_\_\_

### To be completed by Physician:

I request that my patient receive the following medication:

Name of pupil \_\_\_\_\_ Diagnosis \_\_\_\_\_

Name of medication \_\_\_\_\_

Prescribed dosage and means of administration \_\_\_\_\_

Time to be taken during school hours \_\_\_\_\_

Date the administration of drug is to begin \_\_\_\_\_ Expected duration of treatment \_\_\_\_\_

Possible side effects and adverse reactions \_\_\_\_\_

Any special instructions for the administration of the drug, including sterile conditions and storage \_\_\_\_\_

Signature \_\_\_\_\_ Phone # \_\_\_\_\_ Date \_\_\_\_\_

**PLEASE SEE REVERSE SIDE FOR SPECIAL INSTRUCTIONS REGARDING ASTHMA INHALERS**

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### Authorization for Dispensing Medication

#### **FOR ASTHMA INHALERS ONLY:**

#### **To be completed by Parent/Guardian and School Official:**

This student is both capable and responsible for self-administering an asthma inhaler.

Parent's Signature \_\_\_\_\_ Yes \_\_\_\_\_ No \_\_\_\_\_

School Official's Signature \_\_\_\_\_ Yes \_\_\_\_\_ No \_\_\_\_\_

This student may carry an asthma inhaler:

Parent's Signature \_\_\_\_\_ Yes \_\_\_\_\_ No \_\_\_\_\_

School Official's Signature \_\_\_\_\_ Yes \_\_\_\_\_ No \_\_\_\_\_

#### **To be completed by Physician:**

- A. The student's name and address \_\_\_\_\_
- B. The name and dose of the medication contained in the inhaler \_\_\_\_\_
- C. Date administration of the medication is to begin \_\_\_\_\_
- D. Date, if known, administration of the medication is to cease \_\_\_\_\_
- E. Written instructions outlining procedures school personnel should follow in the event that the asthma medication does not produce the expected relief from the student's asthma attack \_\_\_\_\_
- F. List any severe adverse reactions that may occur to the child using the inhaler and that should be reported to the physician \_\_\_\_\_
- G. List any severe adverse reactions that may occur to another child, for whom the inhaler is not prescribed, should such a child receive a dose of the medication \_\_\_\_\_
- H. **List at least one** emergency telephone number for contacting the physician in case of an emergency  
Name \_\_\_\_\_ Phone # \_\_\_\_\_
- I. **List at least one** emergency telephone number for contacting the parent, guardian, or other person having care or charge of the student in an emergency  
Name \_\_\_\_\_ Relationship \_\_\_\_\_ Phone # \_\_\_\_\_  
Name \_\_\_\_\_ Relationship \_\_\_\_\_ Phone # \_\_\_\_\_
- J. Other special instructions from the physician \_\_\_\_\_

Physician's Signature \_\_\_\_\_ Date \_\_\_\_\_