Medication Administration Request

Jefferson County Schools

Student Name: _____ Date of Birth: _____

Allergies: _____ Grade: _____

Physician: _____ School: _____

Prescription (Homeopathic, herbal, natural remedies cannot be delegated without physician's order.)

Medication:_____ Dosage:_____

Time of Day to be Given, or Schedule:_____ Start Date:_____

Expected Days of Use:_____

Reason for Medication:_____

Possible Side Effects:_____

Physician Signature _____ Date: _____ Phone: _____

(Physician Signature is needed only if current the prescription label is not provided)

Non-Prescription (Over the Counter)

Medication: _____ Dosage: _____

Time of Day to be Given, or Schedule: (please specify)

Medication to be given on a set schedule every _____ hours, or at _____ o'clock

Medication to be given only when needed every _____ hours

Start Date: _____ Expected Days of Use: _____

Reason for Medication: _____

The following is to be completed by the parent/guardian:

The medication must be brought to school in the original container appropriately labeled with student name. Prescription medications must be labeled by the pharmacy or physician, stating the name of the student, the date, the medication, the dosage, and the number of days to be administered.

This request is valid for the current school year only.

I hereby certify that my son or daughter, named above, has previously had at least one dose of the above medication and had no adverse reactions. I request that this medication be administered at school as directed above. I understand that it is my responsibility to furnish this medication. Further, I understand school policies regarding medication administration.

I hereby authorize my child's school's nursing personnel to exchange information regarding this request/medication or this prescription, with the physician or with the pharmacy as identified on the affixed label for purposes of clarification or risk assessment.

Signature of Parent/Guardian: _____ Date: _____

School Use:

Prescription Number: _____ Pharmacy: _____

Prescription Date: _____ Staff Initial: _____