New Albany-Floyd County Consolidated School Corporation School Health Services
2014-2015 School Year

Request for Administration of Medication

To be completed by prescribing Health Care Provider

Student's Name_____ **Date of Birth** _____

School_____ **Teacher**_____ **Grade**_____

Condition for which medication is being administered _____

Please administer to the student named above the following medication:

Name of Medication_____

Dosage _____ **Route** _____

Time to be given* _____

***If as needed, state frequency/for what symptoms** _____

Relevant side effects: ☐ None expected ☐Specify: _____

Please also complete this portion for *inhalers and emergency medications* that should be kept with student:

For Emergency Meds

Possession and Self-Administration of Emergency Medication Authorization/Approval

According to IC 20-33-8-13, a student with a chronic disease or medical condition may possess and self-administer emergency medication for the chronic disease or medical condition if parent and physician authorization is given.

- Parent to complete:

  Parent/Guardian authorization for ☐ possession and/or ☐ self-administration:

  _____
  Parent Signature Date

- Prescriber to complete:

  The nature of the disease or medical condition may require emergency administration of the medication. ☐Yes ☐No

  The student has been instructed in how to self-administer this medication. ☐Yes ☐No

  Prescriber authorization for ☐ possession and/or ☐ self-administration:

  _____
  Prescriber Signature Date

- **It is understood that the medication is to be furnished to the school by the parent or guardian on a daily dosage basis. Over-the-counter medication must be provided in its original container. Prescription medication is to be furnished in a pharmacy-labeled container that matches the medication orders above.**
- **By signing, I give permission for the school nurse and prescribing health care provider to exchange information regarding any necessary medication order clarifications, response to medication, and adverse effects.**
- **Unless other arrangements are made, I give the school permission to send home medication that has been in its possession with my child at the end of the school year.**

_____ _____
Parent or Guardian's Signature **Date**

_____ _____ _____
Doctor's Printed Name **Doctor's Phone Number** **Doctor's Fax Number**

_____ _____
Doctor's Signature **Date**

THIS FORM MUST BE RENEWED AT THE BEGINNING OF EACH SCHOOL YEAR