NORTH UNION LOCAL SCHOOL DISTRICT

Physician's Medication Procedure Request Form

(Please use for prescription and/or nonprescription medication. Answers should be typed or printing legibly.)

Date ______________

_______________________________ is under my care for ________________________ and
(Name of Student) (Diagnosis)

it is medically necessary for this student to receive medication during the school day.

Student's address: ____

He/she should receive _______________ of __________________________________ at the
(Dosage) (Name of Drug/Medication)
following times: ______________ ____________ ____________

Specific instructions for administration: ____

Adverse reactions that should be reported to the physician: _________________________

Other special instructions: ____

Expiration date of this request: ____
(*Note: Cannot extend beyond the current school year)*

For students with asthma inhalers or Epi-pens: (Please circle one) - Inhaler Epi-pen
Inhaler/Epi-pen to be kept (check one):____ in school office ____with student at all times

Amount of time needed between doses (inhaler): __________________________________

Possible circumstances in which Epi-pen should be used: _______________________
____

Procedure to follow if the medication does not produce the expected relief from the attack:
____

Student has received training in use of inhaler or Epi-pen: ______ Yes _____ No

Other comments or information: ____

Physician's authorizing signature: ____

Physician's printed name and address: ___________________________________

Phone No. ____________________ ___________________________________

Fax No. _____________________ ___________________________________

N***ote: A new form must be completed if dosage changes.***

PARENT/GUARDIAN MUST COMPLETE INFORMATION ON REVERSE SIDE.

This form, with both sides completed, should be promptly returned to the school office.

PARENT'S REQUEST FOR THE ADMINISTRATION OF MEDICATION BY SCHOOL PERSONNEL

Date: ________________

Name of Student: ______________________________ School: _________________

I hereby request and give my permission to the principal or his/her designee and the school nurse to administer the following medication to my child:

_______________________	_________________	__________________
Name of Medication	Dosage	Route

At the following times: ____

Name and Phone Number of Physician to be contacted if questions arise:

___________________________	__________________________________
(Physician's Name)	(Physician's area code and phone number)

I give my permission for administration of medications at school as described above. I also give permission for the principal or school nurse to contact the physician listed above should questions about medication arise.

Signature of Parent/Guardian ____

Home Area Code and Phone Number: _______________________________________

Work Area Code and Phone Number: _______________________________________

Person to be called if a medical situation arises and I cannot be reached:

___________________________	_______________	_______________________
Name	Relationship	(Area Code) Phone Number

This form, with both sides completed, should be promptly returned to the school office.