

**2024-2025**

**REQUEST FOR ADMINISTERING PRESCRIBED MEDICATION AT SCHOOL**

Student Name:	Date of Birth:
Grade/Section:	Teacher (lower school only):

NAME OF MEDICATION:		Expiration Date:	
DOSAGE:	TIMES TO BE GIVEN (clinic hours 0800-1500)		
DURATION:	Entire School Year ( <i>until directed otherwise</i> )    Other duration:		
REASON FOR MEDICATION:			
QUANTITY GIVEN TO SCHOOL			
Current weight:			
Medication Allergies:			
Any additional information?			

PLEASE NOTE:

1. Written authorization is required to **discontinue** prescription medication.
2. Medication will be dispensed during clinic hours only.
3. **CONTROLLED SUBSTANCES MAY ONLY BE RECEIVED BY A SCHOOL NURSE OR DESIGNATED PERSONNEL.**

**CONSENT**

Parent Consent: I consent to and authorize the health care provider to disclose health information to the school, and for the school to disclose the above information to those within the school district who have a need to know for legitimate educational purposes.

I understand that medications are to be dispensed during clinic hours only.

PARENT/GUARDIAN SIGNATURE:		DATE:	
PARENT CELL PHONE ( <i>or best daytime number</i> ):			

**NOTE:** PLEASE INDICATE BELOW YOUR PREFERENCE FOR DISPOSITION OF ANY UNUSED PORTION OF YOUR CHILD'S MEDICATION.

- Parent will pick up unused medication.
- Please send home unused medication with student.

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**CLINIC USE ONLY**

Date received:	Quantity Received:	Total amount:	RN Signature:	Parent/ Guardian Signature:

Sent Home Date: \_\_\_\_\_

Quantity Sent Home: \_\_\_\_\_

Sent Home With: \_\_\_\_\_

Nurse Signature: \_\_\_\_\_

Controlled substances/Epi pens and Seizure medications need to be dropped off and picked up by a parent/legal guardian and may not be sent home with the student.