St. Ignatius
ADMINISTRATION OF MEDICATION FORM

School policy and state law require consent of the parent/legal guardian and written statement from the licensed prescriber before school personnel can give any medication to a student. (The only exception is the medication listed on the Over The Counter Medication Form.) Please return this completed form to the school office.

Name of Student____DOB_______________Grade__________Homeroom ________

Address____Telephone _______________________________

Allergies ____

To be completed by LICENSED PRESCRIBER

Name of Medication: ____ Dosage: __________________________ Route: __________

Time/Frequency to administer:____

Specific instructions for administration: ____

Condition for which medication is administered: ____

Possible side effects to be noted/reported: ____

Special conditions for storage of medication: ____

Effective Date of this request: ___________________________________ Expiration Date of this request: _____________________

For ASTHMA INHALERS, EPI-PENS, INSULIN PUMPS – In my opinion, this student shows the ability to administer and be responsible for carrying and self-administering the above medication. YES _______ NO ________

Please provide *Emergency Action Plan* with procedures to follow if the emergency medication does not alleviate student's emergency.

Instructions to follow in the event medication does not produce expected response: ____

____

____ ____

Licensed Prescriber Signature Print Name

____/____/____ _____________________________

Date Phone Number

To be completed by PARENT/GUARDIAN

I give permission for the principal or his/her designee to administer the medication as prescribed above to my child, and further agree to the following:

1. Submit to school personnel a revised statement, signed by the licensed prescriber of the above, when any change in the original statement occurs.
2. Submit to school personnel a written statement when medication has been discontinued.
3. Grant permission for the school nurse to confer with the above licensed prescriber regarding my child's health and treatment issues as they pertain to the above medication/diagnosis and his/her educational and behavioral management needs.
4. Cooperate with school personnel in assisting my child comply with medication administration instructions.
5. All medications must come to school in the original container from the pharmacist, clearly marked with student's name, medication name, dose directions, doctor, and prescription number.

FOR INHALERS, EPI-PENS, AND INSULIN PUMPS: It is my opinion that my child understands the use of this medication, demonstrates proper administration and has shown responsible behavior when it comes to carrying this medication. _____Yes ____No

____ ____/____/____ ___________________________

Parent//Guardian Signature Date Daytime Phone Number

**** THIS FORM EXPIRES THAT THE END OF THE SCHOOL YEAR