Chapman USD 473
Request to Administer Medication at School

Student: _____

School: _____ Grade: _____

Teacher: _____

Medication: _____ Dosage: _____

Date Started: _____ Reason: _____

Time of day medication to be administered: _____

Anticipated number of days to be administered at school: _____

Physician Signature: _____ Date: _____

ASTHMA/DIABETIC/EPI-PEN STUDENTS ONLY:

This student is both capable and responsible for self-administering:
_____No _____Yes-Supervised _____Yes-Unsupervised
This student may carry his/her own insulin/inhaler/epi-pen:

_____No _____Yes

I hereby give my permission for _____ to take the above medication at school as ordered. I understand that it is my responsibility to furnish this medication. I further understand that any school employee who administers any drug to my student in accordance with written instructions from the physician/dentist shall not be liable for damages as a result of an adverse drug reaction suffered by the student. This student has had at least one dose of the medication and did not have an adverse drug reaction.

Date: _____ _____
Signature of parent/guardian

***__Note:__ __ALL__ prescriptions __MUST__ be brought to school in the original container and properly labeled from pharmacy. Over the counter medication __MUST__ be in the original container with student's name written on the package. If the medication does not have this signed form, and/or is not in the original container from the store or pharmacy the medication __CANNOT BE GIVEN__. __DO NOT__ send medication to school with your child on the bus. All medication __MUST__ be checked in through the school office.

_____
School Nurse