DEKALB COUNTY SCHOOL DISTRICT
STUDENT HEALTH SERVICES

PHYSICIAN'S REQUEST FOR ADMINISTRATION OF MEDICATION
IN SCHOOL BUILDING DURING SCHOOL HOURS
Must be Completed Annually

1. To keep this child in optimal health and to help maintain school performance, it is necessary that medication be given during school hours.
2. Nurses and other designated school personnel can assist with self administration of medication during school hours.
3. In order for medication to be self administered at school, this form must be completed by licensed physician and at least one guardian/parent and be returned to school.

School:_____

Name of child:_____ DOB:_____

Diagnosis:_____ Infectious _____ Noninfectious_____
(Please check one)

Allergies:_____

Name of medication:_____ Color, if applicable_____
(Include trade name)

Route of Administration:_____
Form of medication to be given (specify below):

_____tablet _____pill _____capsule _____liquid _____inhalation _____injection** _____other

****No injection will be given except in extreme emergency, such as allergy to wasp or bee sting or the like.**

Dosage (amount to be given): _____ Frequency:_____

Side Effects:_____

_____ _____
Physician's Signature (date) Physician's Name (print or type)

_____
Physician's Office Phone/Fax #

****This is my permission to give medication to my child named above as requested by the physician.**

_____ _____/_____
Parent's Signature (date) Home Phone # Work Phone #

_____/_____/_____
Pager/Cell # Email Address

***MEDICATION MUST BE DELIVERED TO SCHOOL BY A RESPONSIBLE ADULT IN THE CONTAINER IN WHICH IT WAS DISPENSED BY THE PRESCRIBING PHYSICIAN, LICENSED PHARMACIST, OR PHARMACY.**

Any Unused and or expired portions of any medications that are not collected by the parent/guardian within one week will be destroyed.

Revised 3/22/11

DEKALB COUNTY SCHOOL DISTRICT
SCHOOL HEALTH PROGRAM/STUDENT SECTION 504

Authorization for Students to Carry

Prescription Inhaler, Epi-Pen, or Insulin

_____ needs to carry the following prescription labeled inhaler, Epi-Pen, or insulin with him/her. The above named student has been instructed in the proper use of the medication and fully understands how to administer this medication. (It is preferable that a second prescription labeled inhaler, Epi-Pen, or additional insulin be kept in the clinic in case the first is lost or left at home.)

_____ _____
Medication Dosage Directions

_____ _____
Physician's Stamp Physician's Signature Date

I have been instructed in the proper use of my prescription labeled medication and fully understand how to administer this medication. I will not allow another student to use my medication under any circumstances. I also understand that should another student use my prescription, the privilege of carrying my medication may be revoked. I also accept the responsibility for checking in with the clinic assistant to keep her informed of the use of my medication in case I start having problems.

_____ _____
Student's Name Student's Signature Date

I hereby request that the above named student, over whom I have legal control, be allowed to carry and use the prescription medication described above while at school. I accept legal responsibility should the above be lost, given, or taken by a person other than the above named student. I understand that if this should happen, the privilege of carrying the medication may be revoked. I release Dekalb County School District and its employees of any legal responsibility when the above named student administers his/her own medication.

_____ _____
Parent/Guardian's Name Parent/Guardian's Signature Date