

REQUEST TO ADMINISTER MEDICATION AT GERSTELL ACADEMY

FOR COMPLETION BY PARENT/GUARDIAN

Name of Student: _____ D.O.B: _____
(LAST) (FIRST)
Name of School: _____ Grade: _____ School Year: _____

In order for my child to receive medication in school, I agree to the following:

- All prescription and non-prescription medication will have a *Physician's* signed order **fully** completed for each school year.
- The prescription medication will be in a container labeled by the Pharmacist or Physician with:
Name of child *Name of the medication* *Dosage, route and time of administration*
Name of physician *Prescription date and expiration date* *Conditions for proper storage*
- The non-prescription medication will be in the original sealed container with the label intact. Student's name will be put on the container in a position that does not obscure the label.
- The medication will be brought to school by an adult.
- The Physician will be called if a question arises about my child's medication.
- The first dose of this medication (except for Epi-Pen) has been given without problems.

Having read the above conditions, I request Gerstell Academy School Nurse or designated personnel, in her absence, administer the medication as prescribed by the Physician below. I certify that I have legal authority to consent to medical treatment for the student named above, including the administration of medication at school.

Signature of Parent/Guardian: _____ **Date:** _____

Relationship to student: _____
Phone Number: (H) _____ (W) _____ Other: _____
Address: _____

FOR COMPLETION BY PHYSICIAN (one medication per form)

Diagnosis: _____
Name of Medication: _____
Dosage: _____
Route: _____ Time of Administration at School: _____ Lunchtime
If PRN, for what symptoms? _____

Please list any specific precautions personnel should be aware of or any unusual effects that might be observed.

Services should begin (Date): _____ Services should terminate (Date): _____

FOR INHALER, EPI-PEN, AND INSULIN ONLY:

- _____ It has been determined that this student is able to self-administer and carry inhalant medication or Epi-pen and has been trained in its use, including knowing when the medication is to be used.
- _____ It has been determined that this student is able to self-administer insulin.
- _____ This student should not self-administer inhalant medication, insulin, or Epi-pen

Physician's Signature: _____ **Date:** _____
Original Signature/NO stamps

Physician's Name (Printed): _____
Address: _____
Telephone Number: _____

FOR COMPLETION BY SCHOOL NURSE

Order Reviewed _____ R.N. Date: _____