

PARENTAL REQUEST FORM FOR PRESCRIBED MEDICATION

 Student's Name (aka) Student's ID Date of Birth
 School and School Hours _____ Lunch Period _____

TO BE COMPLETED BY PHYSICIAN OR AUTHORIZED PRESCRIBER

Diagnosis/Reason for Medication: _____

Name of Medication(s): _____

Medication Form: tablet/capsule liquid inhaler
 injection other _____

Special Storage Requirements: refrigerate none other _____

Start Date: _____

Stop Date: end of school year other/duration: _____
 for episodic/emergency events only

Instructions (Schedule and dosage to be given):

At School: _____

At Home: _____

(please include all medications taken daily)

Restrictions/Side Effects: _____

Is student capable and responsible for self-administering this medication:

No Yes (supervised) Yes (unsupervised)

May student carry this medication? Yes No

Please indicate if you have provided additional information: Yes No

If so, describe: _____

Date: _____ Signature: _____

(Authorized Provider)

Physician's Printed Name: _____

Address: _____

Phone Number and Emergency Number _____

TO BE COMPLETED BY PARENT/GUARDIAN

I give permission for my child, _____, to receive the above medication at school according to the CMSD policy. It is understood that the CMSD and all of its school personnel are absolved from any responsibility, which might be associated with the administration of such medication. I understand that the medication must be brought to school in the container in which the pharmacist dispensed it. It is also understood that by requesting CMSD personnel to administer medication to my child that I also allow the prescriber to communicate with the school nurse regarding my child's treatment plan.

Date: _____ Signature of Parent: _____

Address: _____

Phone Number: (home) _____ (work/emergency) _____

Reviewed by Nurse (name): _____ Date: _____