GLADEWATER INDEPENDENT SCHOOL DISTRICT
Request for Administration of Medication

Campus: _____ Date Form Received by School:_____

We would like to ensure the safest medication administration while your child is away from home. Please complete the information below.

- All medication prescription or non-prescription must be in the original container.
- Prescription medicine must have a pharmacy label for the student in question.
- If medicine is to be given during the school day it must be accompanied by a note signed by a parent or guardian giving authorized school personnel directions for its administration (time and dosage).
- School personnel will not give any medicine, including Tylenol, unless it is provided by you, in the appropriate manner as stated above.

In accordance with Board of Nurse Examiners, the school nurse has the responsibility and authority to refuse to administer medications that, in his or her judgment, are not in the best interest of the student.

Student:_____ Age_____ Grade _____ Teacher_____

Medication: _____

Reason for medication: _____

Dosage to be Given: _____ (Can not exceed label without RX) **Time** to be Given: _____

Start: ☐ date form received Other date: _____ Stop: ☐ end of school year Other date/duration:_____

☐ Last time medication was given: _____

Form of medication / treatment:

☐ Tablet / capsule ☐ Liquid ☐ Inhaler ☐ Nebulizer ☐ Other _____

☐ For Episodic / Emergency events only: ☐Epipen ☐ Glucagon ☐ Diastat (Staff to call district RN)

Restrictions and or important side effects: ☐ None anticipated

☐ Yes, Please describe: _____

Special Storage Requirements: ☐ None ☐ Refrigerate ☐ Other _____

Completed Physician Order Must Accompany for use of Inhaler / EpiPens / Insulin

The student is both capable and responsible for self administering this medication:

☐ NO ☐ Yes – Supervised ☐ Yes – Unsupervised

The student may carry this medication: ☐ No ☐ Yes

Date received: Asthma Action Plan _____ EpiPen Plan _____ Diabetic Plan _____

Please indicate if you have provided additional information: ☐ As an attachment

Physician's Name: _____

Fax Number:_____ Phone Number: _____

To the school: Please report concerns about medications or disease to the above physician

To be completed by parent / guardian

I give permission for (name of child) _____ to receive the above medication at school according to standard school policy. I understand that medication should not be transported on school buses.

Date: _____ Signature: _____ Relationship: _____

Parent Phone Number: _____

Revised 1/10/2014

School _____ **Student Medication Log** Year _____/_____

Last Name _____ First Name _____ Grade _____ Teacher _____

Medication _____ Start Date_____ End Date _____

Dose _____ Time _____ Brought in by: _____

	1	2	3	4	5	6	7	8	9	10	11	12	13	14	15	16	17	18	19	20	21	22	23	24	25	26	27	28	29	30	31
August																															
September																															
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January																															
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Nurses Notes (*Office Use only)*	Medication Count (CT)						Codes	Initials	Signature
	Date	CT	Initials	Date	CT	Initials	A = Absent NA = Not Available NS = No Show H = Hold R = Refused X = No School PR = Parent requested meds given at unscheduled time MR =Meds Requested FT = Field Trip		