NEW PHILADELPHIA CITY SCHOOLS

PHYSICIAN'S REQUEST FOR THE ADMINISTRATION OF PRESCRIPTION MEDICATION BY SCHOOL PERSONNEL
(PLEASE PRINT LEGIBLY AND COMPLETE ALL AREAS)

Building _____ Student's Address _____

Grade _____ _____

_____ Is under my care and should receive _____
(Name of Student) (Name of drug, dosage, route)

At the following times: _____.

This medication is being prescribed for treatment of _____.

Specific instructions for administration of medication, including sterile conditions, storage, and if inhale/Epinephrine auto injector; procedure to follow in the event the medication does not produce the expected relief:

_____

_____

Significant side effects (adverse reactions) which should be reported to physician: _____

_____

Significant side effects (adverse reactions) that may occur to another student whom the medication is not prescribed: _____

_____

Administration of medication to begin _____ and end _____
(date) (date)

For auto injector or inhaler medication: as the prescriber I have determined that this student is capable of possessing and using this auto injector or inhaler appropriately and have provided the student with training in the proper use of the auto injector or inhaler.

_____ _____
(Physician's Signature) (date)

_____ _____
(Physician's Name –PLEASE PRINT) (phone number)

THIS PORTION TO BE COMPLETED BY PARENT/GUARDIAN

PARENT PERMISSION: I request, New Philadelphia City Schools personnel to administration the above medications to

_____
(Student's Name)

Reasonable care will be exercised in the administration on medications. I also give my permission for the school nurse to communicate with the physician regarding this medication. I understand that this is necessary to ensure the safe administration of this medication. A parent/guardian must transport all medication to school personnel. If applicable; as the parent/guardian of this student, you authorize your child to possess the use of asthma in haler/epinephrine auto injector as prescribed, at the school and any activity, event, or program sponsored by or in which the student's school is a participant. As the parent/guardian, you understand that a school employee will immediately from an emergency medical service provider if the epinephrine is administered. **You must provide a backup dose of the epinephrine medication to the school as required by law.**

MEDICATIONS MUST BE SUPPLIED TO THE SCHOOL IN THE ORIGINAL CONTAINER.

_____ _____
Parent/Guardian Signature Date