GREENFIELD-CENTRAL COMMUNITY SCHOOL CORPORATION

REQUEST AND AUTHORIZATION TO ADMINISTER PRESCRIPTION MEDICATION
2012-2013 SCHOOL YEAR
All spaces must be complete before medication will be administered at school. This is a two-sided form.

To Be Completed by Prescribing Health Care Provider

Name of Student: ______________________ Date of Birth: ______________ Grade: ________

Medication Name: ______________________ Dose: ______________ Route: ________

Condition for which medication is being prescribed: ______________________

Time of day dose is to be administered at school: ______________ If "as needed", frequency: ______________

If "as needed", please list specific symptoms requiring medication:

____

Start Date of Medication: ______________ Stop Date (dose will be given on the date specified, but not after): ______________

Side effects: _____ None expected _____ Specify: ______________________

Prescriber's Printed Name and Title: ______________________ Telephone: ______________

Address: ______________________ Fax: ______________

Prescriber's Signature: ______________________ Date: ______________

To Be Completed by Parent/Guardian

I request that school personnel administer medication as prescribed by the health care provider. I certify that I have legal authority to consent to medical treatment for the student named above, including the administration of medication at school.

I authorize the school corporation nurse to communicate with the prescribing health care provider regarding this student's medical condition.

I give permission for my student's medical information to be shared with teachers and other school personnel.

I agree to abide by the guidelines regarding prescription medication administration at school.

Parent/Guardian's Printed Name: ______________________

Cell Phone Number: ______________________ Work Number: ______________________

Home Number: ______________________ Email Address: ______________________

Parent/Guardian's Signature: ______________________ Date: ______________

5330 F1b

REQUEST TO ADMINISTER OVER THE COUNTER MEDICATION

Please give to ____, in the ______ grade, the following medication:
Student's Name

____ ____
Name of Medicine and Strength *Amount or How Many to be Given (cannot exceed recommended dosage on bottle)*

____ ____
Time or How Often to be Given *For the Treatment of*

Special Instructions: ____

____ ____________________
Parent's Signature *Date*

NOTE TO PARENT: All unused or discontinued medication will need to be picked up by the parent. If it is not picked up, it will be discarded by clinic personnel.

February 2013

5330 F1b

REQUEST TO ADMINISTER OVER THE COUNTER MEDICATION

Please give to ____, in the ______ grade, the following medication:
Student's Name

____ ____
Name of Medicine and Strength *Amount or How Many to be Given (cannot exceed recommended dosage on bottle)*

____ ____
Time or How Often to be Given *For the Treatment of*

Special Instructions: ____

____ ____________________
Parent's Signature *Date*

NOTE TO PARENT: All unused or discontinued medication will need to be picked up by the parent. If it is not picked up, it will be discarded by clinic personnel.

February 2013