DIVISION OF SCHOOL HEALTH SERVICES

REQUEST FOR ADMINISTRATION OF MEDICATION *or* USE OF SUCTION, OXYGEN *or* OTHER EQUIPMENT IN SCHOOL

(PLEASE SEE MESSAGE TO PHYSICIAN AND PARENT ON BACK OF FORM)

PHYSICIAN, PLEASE NOTE:
**Please: Fill in all of the spaces. Missing information will cause the form to be returned to you. This will cause a delay in your Patient receiving medication / treatment.*

NAME OF PATIENT/PUPIL	ADDRESS/ZIP		ROOM/BOOK NO.
DATE OF BIRTH	SCHOOL/LOC.#	REGION	PDIF

DIAGNOSIS:

REASON MEDICATION MUST BE GIVEN IN SCHOOL: _____

NAME OF MEDICATION/EQUIPMENT/TREATMENT: | DOSE:

TIME(S) TO BE GIVEN IN SCHOOL: | TOTAL DOSAGE PER 24 HRS:

DATE BEGIN: | DATE END:

INSTRUCTION FOR ADMINISTRATION/UTILIZATION: _____

CONTRAINDICATIONS: _____

SIDE EFFECTS: _____

TREATMENT OF SIDE EFFECTS/ACTION TO BE TAKEN: _____

IS ANY RESTRICTION ON ACTIVITY NECESSARY: YES ☐ NO ☐

IF YES, DESCRIBE: _____

IS PUPIL TAKING ANY OTHER MEDICATION? YES ☐ NO ☐

IF YES, NAME OF MEDICATIONS: _____

IS SIMILAR EQUIPMENT KEPT BY THE CHILD'S FAMILY AT HOME? YES ☐ NO ☐

PRINT NAME OF HEALTH CARE PROVIDER/CREDENTIALS	TELEPHONE
ADDRESS	EMERGENCY NUMBER
SIGNATURE OF HEALTH CARE PROVIDER	DATE SIGNED

I

To The Principal

I authorize selected school personnel to administer the above medication, or to use the equipment or machinery as prescribed by my child's health care provider, whose signature appears on this form.

My child may self-administer medication/equipment as determined appropriate by the school nurse.

I authorize the school nurse to contact my child's health care provider as needed regarding this medication/equipment and/or my child's response.

PARENT SIGNATURE _____ TELEPHONE NUMBER _____

DATE SIGNED _____ EMERGENCY NUMBER _____

II

TO BE COMPLETED BY SCHOOL NURSE AFTER REVIEW AND PRIOR TO SUBMISSION TO SCHOOL HEALTH SERVICES

(SUBMIT ALL THREE COPIES)

PRINT NAME OF SCHOOL NURSE _____

SIGNATURE OF SCHOOL NURSE _____

TELEPHONE NUMBER _____ DATE SENT TO SHS _____

OR

III

IN ACCORDANCE WITH CURRENT SCHOOL HEALTH SERVICES PROCEDURE, THE ADMINISTRATION OF THIS MEDICATION COMMENCED ON _____.
(DATE)

(RETAIN THE SCHOOL COPY)

PRINT NAME OF SCHOOL NURSE _____

SIGNATURE OF SCHOOL NURSE _____

TELEPHONE NUMBER _____ DATE SENT TO SHS _____

IV

FOR THE DIVISION OF SCHOOL HEALTH SERVICES USE ONLY

DATE RECEIVED _____ DATE APPROVED _____

DATE COPY SENT TO SCHOOL NURSE _____ DATE COPY SENT TO RNS _____

SIGNATURE OF SCHOOL HEALTH SERVICES PHYSICIAN/ADMINISTRATOR _____