Plumas Charter School

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PARENT REQUEST FOR ADMINISTRATION OF MEDICATION AT SCHOOL

This form must be completed with physician AND parent/guardian signature BEFORE any medication can be administered at school. This form must be renewed annually and when there are changes to the prescription.

Student Name: _____ **Date of Birth:** _____

School Site: _____ **Teacher:** _____

Health Care Provider:_____ **Provider's Phone:** _____

TO BE COMPLETED BY HEALTH CARE PROVIDER

Medication #1: _____

Reason for Medication: _____

Dosage: _____
Time: _____
Route: _____

Medication to be continued until (date):_____

Side effects to note: _____

Medication #2: _____

Reason for Medication: _____

Dosage: _____
Time: _____
Route: _____

Medication to be continued until (date):_____

Side effects to note: _____

If applicable: Student has been trained to use and may carry and self-administer: Asthma inhaler/ EpiPen

It is necessary for this medication to be taken during the school day at the time(s) indicated above and unlicensed trained school personnel may administer the medication.

Health Care Provider's signature: _____License No:_____
Health Care Provider's name (printed): _____Date: _____
Address: _____ Phone: _____ Fax: _____

TO BE COMPLETED BY PARENT/GUARDIAN

I authorize school personnel to administer the above medication to my child as ordered by the Health Care Provider. I also authorize the school nurse to consult the Health Care Provider named above regarding my child's medication needs. I will notify the school if the medication has changed or is no longer needed. I understand that the medication must be furnished in its pharmacy-labeled container and must be prescribed to my student. I understand that no medication (including over-the-counter) will be given at school without a current prescription from a health care provider.

Parent/Guardian signature: _____Date: _____
Printed Name: _____
Address: _____Daytime Phone: _____

Date of Receipt: _____ **School Staff signature**: _____