KIRTLAND LOCAL SCHOOLS

Request Form for the Administration of Prescription Medication at School

To Be Completed by the Physician

To:_____ School District Personnel;

Since medication for the student listed below cannot be scheduled for other than school hours and the administration of such medication may be supervised by non-medical personnel, it is requested that the medication as indicated below be administered by the school principal or his designee.

1. Name of Student:_____ Date of Request:_____
2. Address of Student:_____ Zip Code:_____
3. School: □ KES □ KMS □ KHS Class:_____ Grade:_____
4. Medication(s) to be Administered:
   a. _____ Purpose:_____
   b. _____ Purpose:_____
5. Possible reaction that, if they occur, should be reported to the physician:
   a. _____
   b. _____
6. Any special instructions (e.g. storage):_____
   _____
7. Medication to be continued as above until: Begin Date:_____
   Discontinued Date:_____
8. Physicians Signature:_____
   Address:_____
   Phone Number:_____ Emergency Number:_____

To be Completed by the Parent or Guardian:

I (we) request that medication be administered to our child: _____in accordance with the above instructions of our physician, Dr. _____ I (we) understand that the administration of said medication is to be done under the supervision of either the principal or a member of the staff selected by the principal. I (we) understand that the medication is to be delivered to the school by the parent or guardian only and unused medication will be returned to the parent or guardian only and that the medication not picked up by the parent or guardian within 3 days of notification will be disposed of by the school principal.

I (we) agree to deliver a school month's supply of medication to the school in the original container the first school day of each month unless other arrangements are made with the principal. We understand that the empty container will be returned home the last school day of each month with the student. I (we) agree to notify the school immediately if:

1. We change physicians.
2. The medication or dose is changed.
3. The administration of the medication is to be terminated.

I (we) give my son or daughter permission to self-administer his / her medication:
Initial: _____ _____
Yes ***No***

Signature of Parent(s) or Guardian(s):

_____ _____
Signature Daytime Phone

_____ _____
Signature Daytime Phone

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Date	*Time*	*Medical Amount*	*Signature*	*Date*	*Time*	*Medical Amount*	*Signature*