Yellow Springs Schools

Request for Assistance in the Self-Administration of PRESCRIBED Medication

*** Some students are able to attend school only through the effective use of medication.
*** When medication is required during the school hours, school personnel may help administer prescibed medication when completed documentation of all information as requested from physician/primary care giver
*** Medication is delivered to the school by parent/guardian in the ORIGINAL LABELED CONTAINER in which is was dispensed by the physician/licensed pharmacist.
*** The container needs to have a PHARMACIST label with the following information:

**** Name of medication - ONLY ONE Medication PER FORM!!!**

* Physician name
* Prescribed dosage & frequency
* Special handling & storage directions
* Date
* Route to take medication
* Pharmacy name & telephone number

Student Name	Grade / Teacher
Address	Allergies
Parent/Guardian Primary Contact phone#	Secondary Contact #

INFORMATION from PRESCRIBED PROVIDER:

The following medication needs to be administered DURING the SCHOOL HOURS and is being prescribed for that time. I understand that unlicensed school personnel may be assisting the child with the self-administration of this medication. This medication has already been administered to this child and there has been no untoward reaction to the medication. School personnel are not liable for effects related to the use of this medication.

NAME of medication (ONLY ONE medication PER form)	
DOSE of medication	
AMOUNT to be administered	
TIME or INTERVAL for medication	
ROUTE to be administered	
if PRN (as needed), give SPECIFIC indications & guidelines for medication	
ADVERSE REACTIONS to report to provider	

Self-Carry: Only check/Initial this box if student has been trained in the proper use of this medication (inhaler or Epipen); is capable of possessing and administering their own medication and responsible enough to keep on their person at all times while at school and school sanctioned events. The parent/guardian will provide the school office with a secondary back-up inhaler and/or Epi-pen in the event the student is unable to self-administer.
Physician [ ]____ (Initial) **Parent [ ]____ (Initial)**

Other:

START date:	END date:
Name: Address: Telephone number:	Prescriber's Signature:

Parent / Guardian Authorization:
I request that the medication prescribed be administered to the student. I agree to submit in writing a revised prescriber statement in the event that any of the required information should change. I give permission for the principal and/or school nurse to contact the health care provider regarding the administration of this medication in the school setting. I agree to deliver the needed medication to the school in a timely manner and in the proper container as noted above. I agree to pick up any remaining medication within THREE days of the termination of administration and/or the end of the school year; if not, school staff will dispose of medication.

Parent/Guardian Name (print)	Signature:	Date:

SCHOOL USE ONLY

Request Accepted:
Request Denied/Reason:
Individual(s) Authorized to assist with medication administration:

Signature of Principle: Date:

Signature of School Nurse: Date:

- [ ] MEDICATION in Med Drawer
- [ ] FIELD TRIP list updated
- [ ] ANNUAL staff training
- [ ] DASL updates