SAD 59 SCHOOL DEPARTMENT
REQUEST/PERMISSION TO ADMINISTER MEDICATION IN SCHOOL
(not including medical marijuana, see separate form)

Student's Name:____ DOB:__________________
School: ________________________ Grade:______ Teacher: ___________________

A. To be completed by Health Care Provider:

Name of medication:____
Reason for medication:____
Form of medication/treatment:
☐ Tablet/capsule ☐ Liquid ☐ Inhaler ☐ Injection ☐ Nebulizer ☐ Other___________
Dosage (amount):____
This medication must be administered during school hours: ☐ Yes ☐ No
If yes, time to be administered:____
Restrictions and/or important side effects (including any restrictions on school activities for safety reasons): ☐ None anticipated ☐ Yes. Please describe in detail:_______________
____
____
Date prescribed:____
Date to be discontinued:____
Any other necessary instructions or information: _____________________________

IF APPLICABLE:
This student is both capable and responsible for self-administering this medication if allowed by Board policy.
☐ No ☐ Yes - supervised ☐ Yes - unsupervised
This student may carry this medication if allowed by Board policy: ☐ No ☐ Yes

NOTE: THE SCHOOL NURSE MAY CONTACT YOU IF THERE ARE FURTHER QUESTIONS CONCERNING THIS MEDICATION REQUEST.

Health Care Provider's Signature:_________________________________Date:______________
Printed Name: ____
Address:____
Phone Number:________________________ Fax Number:______________________________
Email Address: _________________________________

Note: Any changes to the information above shall require a new request/permission form.

B. To be completed by parent/guardian:

I request and give permission for ________________Department nurses and other trained, unlicensed personnel to administer the above named medication to (student's name) __ ______________________________ in accordance with Board Policy JLCD – Administering Medications to Students.

OR:

I request and give permission for (student's name) ___________________ to self-administer the above-named medication in accordance with Board Policy JLCD – Administering Medications to Students.

I understand and agree that if the school nurse has questions regarding the health care provider's order, that the nurse may contact the child's provider and obtain additional information about the medication. I consent to the provider releasing that information.

Signature:__________________________________ Relationship:____________
____

Date: _____________________________________

C. To be completed by school:

Date received: ______________________________ By whom:___________________________
Date reviewed:_______________________________Reviewed by:_______________________
Notes:____