



# The Whole Learning School

Individualized Learning · Special Needs · Small Classes

## ADMINISTRATION OF MEDICATION DURING THE SCHOOL DAY

Parents of pupils requesting that non-prescription medication be administered during school hours by school staff\* are requested to provide for the school:



- 1) parental release and
- 2) medication supplied in the original container

Pupil's Name \_\_\_\_\_ Address \_\_\_\_\_

DOB \_\_\_\_\_ School \_\_\_\_\_ Teacher \_\_\_\_\_ Grade/Home Room \_\_\_\_\_

### PARENT AUTHORIZATION TO ADMINISTER NON-PRESCRIPTION MEDICATION

Medication: \_\_\_\_\_ Dose \_\_\_\_\_ Time \_\_\_\_\_ Route \_\_\_\_\_

For treatment of \_\_\_\_\_ Possible side effects \_\_\_\_\_

Special instructions \_\_\_\_\_ Last date to be given \_\_\_\_\_

Medication ALLERGIES: \_\_\_\_\_

### PARENTAL REQUEST FOR ADMINISTRATION OF MEDICATION

I request this medication be given as requested. I release school personnel from any liability in the administration of this medication at school. \*I understand that medication will not necessarily be administered by a school nurse.

Parent/Guardian Signature \_\_\_\_\_

Date \_\_\_\_\_ Home Phone \_\_\_\_\_ Work Phone \_\_\_\_\_

## ADMINISTRATION OF MEDICATION DURING THE SCHOOL DAY

Parents of pupils requesting that medication be administered during school hours by school staff\* are requested to provide for the school:

- 1) the physician's order,
- 2) a parental release, and
- 3) medication supplied in the original container.

Ask for prescription medication to be divided in two bottles completely Labeled - one for home and one for school.

Place student  
photo here  
(optional)

Pupil's Name \_\_\_\_\_ Address \_\_\_\_\_

DOB \_\_\_\_\_ School \_\_\_\_\_ Teacher \_\_\_\_\_ Grade/Home Room \_\_\_\_\_

### PHYSICIAN'S ORDER FOR ADMINISTRATION OF MEDICATION BY SCHOOL PERSONNEL

I have prescribed the following medication for this student and request the dosages be given during school hours:

Medication: \_\_\_\_\_ Dose \_\_\_\_\_ Time \_\_\_\_\_ Route \_\_\_\_\_

(Morning medication dose \_\_\_\_\_ mg to be given at school only if student forgets to take it at home.)

For treatment of \_\_\_\_\_ Possible side effects \_\_\_\_\_

Special instructions \_\_\_\_\_ Last date to be given \_\_\_\_\_

Medication ALLERGIES: \_\_\_\_\_

Physician's Signature \_\_\_\_\_ Date \_\_\_\_\_ Phone \_\_\_\_\_

Print physician's name and office address \_\_\_\_\_

### PARENTAL REQUEST FOR ADMINISTRATION OF MEDICATION

I request this medication be given as prescribed and I give the Licensed School Nurse authority to communicate with the ordering physician about this medication. I release school personnel from any liability in the administration of this medication at school. \*I understand that medication will not necessarily be administered by a school nurse.

Physician and I agree that this student needs medication on field trips. Yes \_\_\_\_\_ No \_\_\_\_\_

Parent/Guardian Signature \_\_\_\_\_

Date \_\_\_\_\_ Home Phone \_\_\_\_\_ Work Phone \_\_\_\_\_