# ST. JAMES PARISH SCHOOL BOARD
# PHYSICIAN/PARENT REQUEST MEDICATION FORM

## PART 1: PARENT OR LEGAL GUARDIAN TO COMPLETE.

Student's Name ______________________________ Birthdate ____________________
School ____________________ Grade ______________ Homeroom ________________
Parent/Guardian Name (print): ________________________ Phone Number: ______________
Emergency Contact Name: __________________________ Phone Number: ______________

I hereby request that the below ordered medication be administered by school personnel. I give permission for the exchange of information between the prescriber, school staff, and school nurse. I understand that that I must supply the school with no more than a 35 day supply of medication. I understand that this medication will be destroyed, if not picked up within 2 weeks from the last day of school. I have administered the initial dose of medication on: Date: ________________ Time: ________________.

**I understand and agree that SJPSB and its employees are not responsible for any unintentional mistakes or oversights in keeping or giving my child medication. I agree to hold the School Board free and harmless from liability from injuries that might occur as a result of the administration of medications by school employees. I am aware that I may view the Medication policy and procedure on the SJPSB website.**

**Parent/Guardian Signature:________________________________________Date:____________**

*Each medication order must be written on a separate order form. Any future changes in directions for medication ordered require new medication orders. Orders sent by fax are acceptable. Legibility may require mailing original to the school. All medication orders must be renewed yearly and can not be dated prior to July 1st of that school year.*

## PART 2: LICENSED PRESCRIBER TO COMPLETE.

1. Student Diagnosis: ______________________________________________
2. Medication: ______________________________________________
3. Strength of medication: ____________________ Dosage (amount to be given): ____________________

Check Route: ❑ By mouth ❑ By inhalation ❑ Other __________________ Time:______________________
PRN Frequency(circle appropriate): q 2 hours q 4 hours q 6 hours

*Note: The frequency and the time of medication order must be the same as the Rx given. School medication orders shall be limited to medication that cannot be administered before or after school hours. Special circumstances must be approved by school nurse.*

4. Duration of medication order: Until end of school term
5. Desired Effect: ______________________________________________
6. Possible side-effects of medication: ______________________________________________
7. Any contraindications for administering medication: ______________________________________________
______________________________________________
8. Other medications being taken by student when not at school: ______________________________________________
______________________________________________
9. Student's Allergies: ______________________________________________

**Prescriber's Name(Printed): ______________________________________________**
**Phone Number: ______________________ Fax Number: ______________________**

**Prescriber's Signature: ______________________________ Date: ____________________**

## PART 3: LICENSED PRESCRIBER/PARENT TO COMPLETE AS APPROPRIATE.

**Inhalants/Emergency Drugs Release Form for Students to be Allowed to Carry Medication on Self**

1. Has this student been adequately instructed by you or your staff and demonstrated competence in self administration of medication to the degree that he/she may self-administer his/her medication at school, provided that the school nurse has determined it is safe and appropriate for this student in his/her particular school setting? ❑ Yes ❑ No

**Prescriber's Signature: ______________________________ Date: ____________________**

2. Do you give permission for your child to self-administer the medication at school? ❑ Yes ❑ No
3. Do you assume responsibility for your child's actions in his/her self-management of medication at school? ❑ Yes ❑ No

**Parent/Guardian Signature: ______________________________ Date:____________________**

**School RN's Signature: ______________________________ Date: ______________**

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