ARMADA AREA SCHOOLS
Krause Elementary 586-784-2600 Fax 586-784-9147

Request for Administration of Prescription Medication to Student

Student _____ Date _____

Under certain conditions, as a service to you and for the welfare of your child, school personnel may agree to honor parent requests for the administration of necessary prescribed medication to students for limited periods of time. All medication must be in the original container, clearly labeled, indicating the following information: Student's name, prescription number, medication name, dosage, date issued, doctor's name, pharmacy name, address and phone number.

TO BE COMPLETED BY PARENT OR LEGAL GUARDIAN:

I do hereby request and authorize prescription medication to be given to my child (student's name) _____ Grade: _____ as indicated by the prescribing physician. I understand that it is the sole responsibility of my child to report to the office for his/her medication. I further understand that it is my responsibility to notify the school of change or discontinuation of the medication(s). I agree to renew this application at the beginning of each school year.

Signature of Parent/Legal Guardian _____

Address: _____ City/Zip: _____

Telephone: _____(home) _____(cell/work)

TO BE COMPLETED BY PHYSICIAN:

I recommend that prescribed medication be given to _____ in school.

Name of Medication: _____ Dosage: _____

Frequency _____ Time Administrated _____

Purpose of Medication _____

Special instructions regarding medication: (Including side effects, adverse reactions, toxicity, hazards, directions, required training for personnel, etc.)

_____

_____

Can dosage be adjusted around school hours? _____

Physician's Signature: _____ Date: _____

Physician's Address: _____

Physician's Telephone Number: _____ Fax Number: _____

5/2016

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APPROVAL FOR POSSESSION AND USE OF INHALERS BY STUDENTS

Parent/Guardian Approval

Date: _____

Student Name: _____

Medication and dosage: _____

I hereby give my permission as parent/guardian for: _____ to have his/her inhaler in his/her possession and to use the inhaler as needed according to the instructions of the physician as listed below.

Signature of Parent/Guardian: _____

Physician Approval

Date: _____

Student/patient name: _____

Medication and dosage: _____

I hereby note my approval to have _____ (student's name) possess and use his/her inhaler while at school or at school activities.

Signature of Physician: _____

5/2016