

REQUEST TO ADMINISTER MEDICATION

Please give to _____, in the _____ grade, the following medication:
Student's Name

Name of Medicine and Strength

Amount or How Many to be Given

Time or How Often to be Given

For the Treatment of

Special Instructions: _____

Do you give permission for us to send leftover medication home with your high school student at the end of the school year? Yes No
Please circle one

Parent's Signature

Date

NOTE TO PARENT: Parental request to administer medication at school is needed for both prescription and non-prescription medicines. 3/08

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AUTHORIZATION TO CARRY INHALER ON SCHOOL GROUNDS

Please allow _____ in the _____ grade to carry his/her
Student's Name

_____ inhaler to use _____
Name of Auto-Injector *Amount or Dosage*

for emergency treatment, when _____.
When to Use

We request that the student be permitted to carry the inhaler on his/her person or to keep it in his/her backpack. He/she has been instructed in and understands the purpose and appropriate method and frequency of use of the prescribed inhaler.

Physician's Signature

Date

Parent's Signature

Date

AUTHORIZATION TO CARRY EPI-PEN ON SCHOOL GROUNDS

Please allow _____ in the _____ grade to carry his/her
Student's Name

_____ auto-injector to use _____
Name of Auto-Injector *Amount or Dosage*

for emergency treatment, when _____.
When to Use

We request that the student be permitted to carry the auto-injector on his/her person or to keep it in his/her backpack. He/she has been instructed in and understands the purpose and appropriate method and frequency of use of the prescribed auto-injector and understands the importance of reporting immediately to the school health assistant after using the auto-injector. We understand that a **911 call** is required after the use of the Epi-Pen auto-injector.

Physician's Signature

Date

Parent's Signature

Date

AUTHORIZATION TO CARRY EMERGENCY MEDICATION

Please allow _____ in the _____ grade to carry his/her
Student's Name

_____ to use _____
Name of Medication *Amount or Dosage*

for treatment of _____
Physician's Diagnosis

at the following times: _____
When to Use

We request that the student be permitted to carry the above emergency medication on his/her person. He/she has been instructed in and understands the purpose and appropriate method and frequency of use of the prescribed medication.

Physician's Signature

Date

Parent's Signature

Date

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