**To Be Completed By The Parent/Guardian**

Student Name: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ DOB: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

I request the school nurse give the medication prescribed by child’s physician, I have provided an order from my child’s Medical Provider. I will provide the medication in the original pharmacy or over the counter container. This plan will be shared with school staff caring for my child.

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_
 **Parent/Guardian Signature Date**

**Initial Medication Delivery**

Name of Medication:

Date: \_\_\_\_\_\_\_\_ Dosage: Time to be given: \_\_\_\_\_\_\_\_\_\_\_\_\_

Number of Pills Received (if count is appropriate):

School Nurse Signature:

Parent / Guardian Signature:

**Parent/Guardian Permission for Independent Use and Carry**
I agree that my child can use their medication effectively and may carry and use this medication independently at any school/school sponsored activity. Staff intervention and support is needed only during an emergency

**RESCUE MEDICATIONS ONLY-**

(Inhaler, Epi-Pen, Glucagon- 7th-12th Grade Only)

Signature: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Date: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

|  |
| --- |
| **For Office Use Only**Provider Name:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Medication Discontinued:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_MD Order Rec’d:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Date Discontinued:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_Date Order Rec’d:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Parent Picked Med Up:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_Date Order Expires:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Number of Pills:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ |

**SUBSEQUENT MEDICATION DELIVERY**

**Date:** \_\_\_\_\_\_\_\_ Number of Pills Received (if count is appropriate):

School Nurse Signature:

Parent / Guardian Signature:

**Date:** \_\_\_\_\_\_\_\_ Number of Pills Received (if count is appropriate):

School Nurse Signature:

Parent / Guardian Signature:

**Date:** \_\_\_\_\_\_\_\_ Number of Pills Received (if count is appropriate):

School Nurse Signature:

Parent / Guardian Signature:

**Date:** \_\_\_\_\_\_\_\_ Number of Pills Received (if count is appropriate):

School Nurse Signature:

Parent / Guardian Signature:

**Date:** \_\_\_\_\_\_\_\_ Number of Pills Received (if count is appropriate):

School Nurse Signature:

Parent / Guardian Signature:

**Date:** \_\_\_\_\_\_\_\_ Number of Pills Received (if count is appropriate):

School Nurse Signature:

Parent / Guardian Signature:

**Date:** \_\_\_\_\_\_\_\_ Number of Pills Received (if count is appropriate):

School Nurse Signature:

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