MEDICATION ADMINISTRATION AT SCHOOL FOR GFW/PLS

___GFW-E ___GFW-M ___GFW-H ___PLS-FX ___PLS-GIBBON

For medication administration during school hours, by school staff, parents need to:

** Have this form signed by Health Care Provider
** Parent signature on this form
** Medication provided in orginal container from your Pharmacist

STUDENT_____ GRADE_____

BIRTHDATE_____

****

TO BE COMPLETED BY HEALTH CARE PROVIDER

MEDICATION_____

___TABLET/CAPSULE ___LIQUID ___NEBULIZER ___INHALE ___INJECTION ___OTHER

DOSAGE & TIME OF ADMINISTRATION_____

REASON FOR MEDICATION_____

START DATE_____ END DATE_____

RESTRICTIONS/SIDE EFFECTS ___NONE ANTICIPATED
___YES, PLEASE DESCRIBE_____

STUDENT CAPABLE OF SELF ADMINISTRING MEDICATION (subject to school policy)
_____NO _____YES-SUPERVISED _____YES-UNSUPERVISED

PROVIDERS SIGNATURE_____ DATE_____

PHONE NUMBER_____ ADDRESS_____

PARENTAL SIGNATURE

I REQUEST THAT THE ABOVE MEDICATION BE GIVEN BY THE SCHOOL AS PRESCRIBED. I UNDERSTAND I MUST PROVIDE THE MEDICATION IN IT'S ORIGINAL CONTAINER PROVIDED BY THE PHARMACIST. I UNDERSTAND THE SCHOOL WILL NOT BE RESPONSIBLE FOR SELF-ADMINISTERED MEDICATIONS.

PARENT_____ DATE_____

HOME PHONE_____ WORK PHONE_____

CELLPHONE_____