Licensed Provider Request for Administration of Medication During School Hours

I, the undersigned licensed provider, request that the school nurse or other designated person administer the medication I have prescribed below. I certify that failure to administer the medication may jeopardize the health of my patient.

STUDENT NAME: ____**DATE OF BIRTH:** ________________

ADDRESS: ____

PARENT/GUARDIAN: ____

PROVIDER NAME (PRINT CLEARLY): ____

PROVIDER ADDRESS: ____TELEPHONE: _______________________

DIAGNOSIS OF STUDENT: ____

NAME, DOSE, ROUTE OF PRESCRIBED MEDICATION(S): A separate prescription must be provided for school use only.

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SPECIFIC TIME/CIRCUMSTANCE UNDER WHICH MEDICATION IS TO BE ADMINISTERED IN SCHOOL:

____

POSSIBLE SIDE EFFECTS OF MEDICATION: ____

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FOR WHAT DURATION SHOULD THIS MEDICATION BE GIVEN? ____

IS THIS STUDENT TAKING ANY OTHER MEDICATION? Please list: _______________________________________

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DO YOU WANT THIS STUDENT TO SELF-ADMINISTER HIS/HER OWN MEDICATION?
YES _____________ NO _______________ (Asthma inhalers and epi-pens only)

CURTAILMENT OF SCHOOL ACTIVITY? YES______________ NO _______________
(Please specify: Sports, shop, lab, driver's training, gym, etc.)____

PROVIDER SIGNATURE: ____**DATE:** ________________

Please mail/fax this request to: ___________________________School Nurse
Fax: 978-722-________ ___________________________School
___________________________Address
Lawrence, MA _____________ (zip code)