WATERFORD UNION HIGH SCHOOL
MEDICATION ADMINISTRATION REQUEST FORM

Name of Student: _____ Date of Birth: _____
School: _____ School Year: _____ Grade: _____
Physician's Name:_____ Physician's Phone: _____
Phone number where Parent/Legal Guardian can be reached during school hours:_____

PARENT/GUARDIAN AUTHORIZATION

I, the parent/guardian of the above named student, have read the school's medication policy and request the medication listed below be administered to my child at school. I understand that qualified, designated persons will be administering the medication. **I will notify the school immediately if there is a change or cancellation of the medication.** The School District has my permission to contact the prescriber in regard to the medication being prescribed.
An over-the-counter medication can be given for 10 days or less with a parent signature. If an over-the-counter medication is to be given for greater than 10 consecutive days, a physician's signature is required below or the medication will not be given. Prescription medications will not be given for more than 2 days unless this form is completed and signed by both the parent and physician.

_____ _____
Date **Signature (parent/guardian)**

BRONCHIAL INHALERS AND EPIPEN:
Provisions for Self Administered Medications at School: 1) No documentation of self administered medication will be kept by the school. 2) The school is not responsible for the safeguarding of self administered medication. 3) The school nurse will attempt to meet with each student annually who self administer medications. 4) Self administered medications also require a parent and physician signature and new paperwork must be received each year.
My child ____CAN ____CANNOT carry and self-administer the prescribed ____ INHALER or ___EPIPEN.

_____ _____
Date **Signature (parent/guardian)**

Medication at School	Dosage	Time(s)	Side Effects	Reason for Med.

PHYSICIAN AUTHORIZATION

I authorize the administration of the medication listed directly above to the student named on this form. I agree to be contacted by the School District as needed regarding the medication.

PRN MEDICATIONS (If applicable)
Indications for use: _____
Plan following administration (if needed) _____

BRONCHIAL INHALERS AND EPIPENS (If applicable)
It is my professional opinion that the student named above _____CAN _____CANNOT carry and self-administer the prescribed _____INHALER or _____EPIPEN. He/she has been instructed in and understands the purpose and appropriate use of the medication.

_____ _____ _____
Date **Signature of Physician** Physician's Name (Printed)

_____ _____
Physician's Address City State/Zip Code Phone