AMBRIDGE AREA SCHOOL DISTRICT

**Request for Medication Administration at School**

\*\*\*To be completed by licensed prescriber: Date:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

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| --- |
| Student’s Name DOB Grade |
| **Medication** | #1 | #2 |
| **Dosage** |  |  |
| **Time of Administration** |  |  |
| **Length of Administration** | Start Stop | Start Stop |
| **Reason for Medication** |  |  |
| **Administration Instructions** |  |  |
| **Side Effects** |  |  |
| **Field Trip** | Please check the following option when a parent/guardian designee (non- staff) is unable to attend a field trip:\_\_\_\_\_Yes, the prescribed dose can be withheld on the day of the trip.\_\_\_\_\_Yes, the time can be adjusted with the parent to be administered upon return to  school.\_\_\_\_\_No, this medication must be given to the child at the prescribed time.   Explanation\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_  |
| **Competency for Self Administration** | I,\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_, certify that this student has a potentially life threatening condition and requires an inhaler, auto injecting epinephrine or insulin. The student is competent and has been instructed in the proper method of self administration of said medication. This student may therefore carry and self administer his/her inhaler, auto injecting epinephrine or insulin.  |
| **Signature of Licensed Prescriber** | Name\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Phone\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_  (Not valid without licensed prescriber signature) |
| **To be completed by the Parent/Guardian:**I give permission for my child to receive the above noted medication at school according to School Board Policy 210 and 210.1. I waive the and release the District and any District employee from any and all liability or responsibility for the administration of the medication or benefits or consequences of the medication and acknowledge that the District bears no responsibility for ensuring that the medication is taken. I also give permission for the school nurse to contact the licensed prescriber, as necessary, regarding the medication. Parent/Guardian Signature:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_(not valid without signature) |
| If there is a two hour delay of opening school: \_\_\_\_\_Yes administer my child’s medication as prescribed. \_\_\_\_\_ No, I will contact you if the time is to be adjusted. |