**ADMINISTRATION FOR PRESCRIPTION MEDICATION BY SCHOOL PERSONNEL**
**PHYSICIAN'S REQUEST**

Date _____

Student's Full Name:_____, is under my care and must take medication which I have prescribed during the school day.

Name of medication being prescribed (as it appears on container in which the medication is stored):

_____

Dosage: _____ Time to be given:_____

Date administration of medication is to Begin: _____ End:_____

Possible adverse reactions to be reported to physician: _____

_____

Special instructions for the provision and storage of the medication

_____

**NOTE: Controlled substances may not be self-administered by students:**

_____ Medication may be self administered by the student, and the student is competent to self-provide medication, I, or my designee(s), and the student have developed a plan for self-provision of the medication(s), the storage of the medication and a plan for reporting and supervision of self-provision of the medication(s), and deem each to be safe and appropriate, and if applicable authorize the use of hypodermic syringes and needles or similar medical items.

_____ Medication may NOT be self administered by the student, I, or my designee(s), have trained school personnel or approved alternative training as adequate to provide the medication, have evaluated the situation, the storage of the medication, the general administration plan and if applicable, the self administration plan or emergency care plan, and deem each to be safe and appropriate, and if applicable authorize the use of hypodermic syringes and needles or similar medical items.

_____ _____

Print or Type Name of Physician Signature of Physician

_____ _____

Primary Phone Number Secondary Phone Number