Request for Administration of Medical/Emergency Medication

A. TO BE COMPLETED BY PARENT OR GUARDIAN

NAME: _____ BIRTHDATE _____
(YR/MONTH/DAY)

PARENT/GUARDIAN _____ HOME TEL _____ BUSINESS TEL _____

PHYSICIAN _____ TELEPHONE _____

B. TO BE COMPLETED BY PRESCRIBING PHYSICIAN (Conditions Which Make Medication necessary)

NAME OF MEDICATION _____ DOSAGE _____ DIRECTIONS FOR USE _____

1. _____

2. _____

3. _____

4. _____

Emergency Medication: _____

***If prescribing epinephrine, emergency medication must be a single dose, single-use auto-injector for the school setting with a second injector that can be given 10-15 minutes if symptoms do not improve. Oral antihistamine will not be administered by school personnel in emergency situations.**

Additional Comments: _____

_____ _____
Physician's Signature Date

C. TO BE COMPLETED BY SCHOOL PERSONNEL AFTER REVIEWING POLICIES AND CHILD SPECIFIC PLANS (CLASSROOM TEACHERS, ADMIN, CEAS, FIRST AID, SUPERVISORS, NOON HOUR SUPERVISORS)

DATE	SIGNATURE	PLAN REVIEWED	POLICY REVIEWED