



## 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