REQUEST FOR ADMINISTRATION OF MEDICATION

Child's Name ______________________ School ______________________

Date of Birth ______________________ Grade ______________________

School Nurse ______________________ Fax # ______________________

To be completed by school nurse/parent and faxed to physician for signature – OR – to be completed by physician at office when prescribing medication and faxed or brought back to school.

Diagnosis ______________________

RX (Dosage/Frequency/Route) ______________________

____

Reportable Adverse Reactions/Side Effects ______________________

____

Beginning Date ______________________ Ending Date ______________________

List other Medications Currently Being Taken ______________________

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Name of Prescribing Physician ______________________

Physician's Signature ______________________ Date ______________

Parent's Signature ______________________ Date ______________

(Parent Signature required for over the counter medications)

I request that the Principal or his/her designee administer the medication as directed above. ***I understand that it is my child's responsibility to report to the office for this service***. I authorize the release of information between the school and physician, and the physician and school regarding my child's diagnosis and medication per HIPAA.

Sign before faxing to physician.

Parent/Guardian Signature	*Date*	*Phone*	*Emergency #*

INHALER/EPI-PEN EXCEPTION:

My child has been instructed in the proper use of the above identified inhaler/epi-pen. I request that he/she be permitted to carry and self-administer the medication as prescribed.

______________________ ______________________

Parent/Guardian Signature Date

PARENT PLEASE NOTE:

STUDENT MEDICATON MUST BE IN THE PRESCRIPTION OR MANUFACTURER'S CONTAINER.

(For Short Term Use)

Date	Time	Initials	Date	Time	Initials

Fremont County School District #24
112 West Third Street
Shoshoni, WY 82649
(307) 876-2563

MEDICATION POLICY

Dear Parent:

According to Fremont County School District #24 Board Policy, when your child needs medication of any type (including over-the-counter medicine) given during school hours, you have the following choices:

1. You may discuss with your doctor an ***alternative schedule of medication*** so that it can be given outside of school hours.
2. You may ***come to the school and give it to your child*** at the appropriate time.
3. You may get a ***Medication Form*** from the school/school nurse and have the ***physician indicate the diagnosis, drug, dose, and time to be given on the form***. Be sure both you and the physician sign the form. The medication must be in a pharmacy labeled or manufacturer's container. All medication will be stored in a designated area that is to remain locked when not in use. Students must take all medications in the presence of designated school personnel.

EXCEPTION: Inhalers and Epi-pens may be carried by the student if the "EXCEPTION" on the Request for Administration of Medication Form on the reverse side of this letter has been signed by both the parent/legal guardian and the physician and is on file in the school nurse's office.

On the reverse side of this letter is the Medication Form. Please feel free to make multiple copies of this form so that you will always have one for the physician and yourself.

Remember that in order for medication to be given at school, it must be the original container and the school Medication Form must be filled out and signed by both you and the physician.

All remaining medication must be picked up from the school by the parent/guardian. At the end of the school year, all medication NOT picked up will be discarded.

This form must be renewed each school year.

Thank you for your cooperation.