PHYSICIAN'S REQUEST FOR ADMINISTERING MEDICINE IN SCHOOL

To: Parent/Guardian and Student's Physician/Dentist

In response to your request for the student to receive medicine during school hours, the prescribing physician or dentist is asked to complete SECTION ONE on the reverse side of this form. Then the parent should complete SECTION TWO and return this form to the school office.

The administering of medicines in the school should be avoided whenever possible. However, when a pupil's health and attendance is contingent upon the receipt of medication during school hours, the Board permits administering medicine in accordance with Policy JLCD. Approval by the Principal is required. This is part of an overall effort to protect the health and safety of the student.

Should a medicine be required to be taken in conjunction with a meal (before, during, or after eating), please clearly indicate that rather than giving a specific time, as the lunch period schedule may vary.

The medicine is to be brought to the school by the parent in the original container, labeled according to standards. It will be kept in a locked cabinet. Please bring only enough for the duration specified.

Please be advised that the school nurse, when available, administers any medication approved to be given. However, in the likely event that the school nurse will not always be present in the school building, the medicine will be administered by the Principal/designee, as is permitted by law and Board policy.

Parents are encouraged to come into the school to give medicines to their own children if they choose to do so.

SECTION ONE

_____ would be unable to attend school if not administered the
Student's Name
following prescribed medicine during the school day. I hereby request the administering of

medicine in school as follows:

Diagnosis_____ Name of Medication_____

Dosage_____Time of Administering_____

(Check if applicable) This student has been trained in the proper technique for self-administration of an _____epinephrine pen _____asthma inhaler.

Possible Side Effects_____

Date to Begin_____ Date to Conclude_____

_____ _____
Physician/Dentist Name (Printed or Typed) Signature

Address_____

Telephone_____ Date of Signature_____

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SECTION TWO

I request that the student be administered medicine in school in response to the doctor's request and information above and in accordance with school board policy. I realize that the medicine will be administered by the school nurse when available, but otherwise by unlicensed (non-medically licensed) personnel (the Principal/designee).

_____ _____
Signature of Parent/Guardian Date

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SECTION THREE

APPROVED BY:

_____ _____
Principal Date

DATE ADOPTED: July 1, 2003
DATE REVISED: October 20, 2005