Maplewood Richmond Heights School District
Health Services

Request for Prescription and/or Over the Counter Medication to be Administered

Aligned with Board Policy JHCD

- **<u>This form must be updated at the beginning of each school year.</u>**
- **Medications to be administered at school must be brought to school in a container appropriately labeled by the pharmacy or physician and be given immediately upon arrival to the school nurse or secretary.**
- **Medicine to be given at school is to remain at school for the period of time it is to be given.**
- **Your pharmacist should label two prescription drug containers, one for home and one for school.**

Student Information

Name: _____ Age: _____ Date of Birth: _____

Grade: _____ Homeroom / Classroom Teacher: _____

Please list any medical information you would like the district to be aware of in order to adequately assist your student in an emergency (for example, medications, allergies, etc.)

_____

_____

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Medication / Prescription Information

_____ Prescription Medication _____Over the Counter Medication Provided by Parent/Guardian

Name of Medication: _____

Reason for Medication: _____

Form of Medication/Treatment: _____Tablet _____Capsule _____Liquid _____Inhaler

_____ Injection _____Nebulizer _____Other

Describe schedule and dose to be given at school: _____

If "as needed", please indicate Maximum dosage per day: _____

Restrictions and/or Important Side Effects: _____Yes _____ No

If yes, please describe: _____

Special Storage Requirements: _____ None _____Refrigeration _____Other

Physician's Information

I give permission for _____ (student) to receive the above medication at school.

Please indicate additional information: _____On the back of this form _____ As an attachment

I also give employees permission to contact the student's doctor about the student's condition. I understand that I have the ultimate responsibility for providing the school with an adequate supply of medication and for informing the school district immediately if any information provided on this form changes, or if administration of medication should cease.

_____ _____

Signature **Date**

Relationship: _____

Home Phone: _____ Work Phone: _____ Emergency Phone: _____

_____

Name of Physician

_____

Address

_____ _____

Phone Number **Fax Number**