

**WESTERN RACINE COUNTY HEALTH DEPARTMENT  
MEDICATION ADMINISTRATION REQUEST FORM**

Student: \_\_\_\_\_ Date of Birth: \_\_\_\_\_  
 School: \_\_\_\_\_ School Year: \_\_\_\_\_ Grade: \_\_\_\_\_  
 MD's Name: \_\_\_\_\_ MD's Phone: \_\_\_\_\_ MD's Fax: \_\_\_\_\_  
 Phone number where Parent/Legal Guardian can be reached during school hours: \_\_\_\_\_

**PARENT/GUARDIAN AUTHORIZATION**

I, the parent/guardian of the above named student, have read the school's medication policy (on reverse side) and request the medication **listed below** be administered to my child at school. I understand that qualified, designated persons will be administering the medication. **I will notify the school immediately if there is a change or cancellation of the medication.** The School District has my permission to contact the prescriber in regard to the medication being prescribed.

If an over-the-counter medication is to be used for greater than 10 consecutive days, a physician's signature **is required below** or the medication will not be given. Prescription medications will not be given for greater than two (2) days unless this form is completed and signed by both the physician and parent. It is impossible to arrange for this medication to be taken at home, and therefore, it must be administered during the school hours: \_\_\_ Yes \_\_\_ No

\_\_\_\_\_  
**Date** **Signature (parent/guardian)**

**BRONCHIAL INHALERS, EPIPENS, and INSULIN.**

Provisions for Self Administered Medications at School: 1) No documentation of self administered medication will be kept by the school. 2) The school is not responsible for the safeguarding of self-administered medication. I have read and agree with these provisions for self-administration. 3) The School Nurse will attempt to meet with each student annually who self-administer medications.

My child \_\_\_ CAN \_\_\_ CANNOT carry and self-administer the prescribed \_\_\_ INHALER, \_\_\_ EPIPEN or \_\_\_ INSULIN.

\_\_\_\_\_  
**Date** **Signature (parent/guardian)**

Medication At School	Dosage	Time(s)	Duration	Side Effects	Reason for Med.
			From:		
			To:		
			From:		
			To:		
			From:		
			To:		

**PHYSICIAN AUTHORIZATION**

I authorize the administration of the **medication listed directly above** to the student named on this form. I agree to be contacted by the School District as needed regarding the medication.

**PRN MEDICATIONS** (If applicable)

Indications for use: \_\_\_\_\_

Plan following administration (if needed) \_\_\_\_\_

**BRONCHIAL INHALERS, EPIPENS AND INSULIN** (If applicable)

It is my professional opinion that the student named above \_\_\_ CAN \_\_\_ CANNOT carry and self-administer the prescribed \_\_\_ INHALER, \_\_\_ INSULIN, or \_\_\_ EPIPEN. He/she has been instructed in and understands the purpose and appropriate use of the medication.

\_\_\_\_\_  
**Date** **Signature of Physician** **Physician's Name (Printed)**

\_\_\_\_\_  
 Physician's Address City State/Zip Code Phone