

**PROVISION OF MEDICATION TO STUDENT
PHYSICIAN'S REQUEST FOR ADMINISTRATION OF PRESCRIPTION
MEDICATION BY SCHOOL PERSONNEL**

Date: _____

_____ (Student's full name) is under my care and must take medication which I have prescribed during the school day.

Name of medication (as it appears on container in which the medication is stored):

Dosage and time: _____

Date provision of medication is to begin: _____

Date after which the medication should not be provided: _____

Possible adverse reactions to be reported to physician: _____

Special instructions for the provision and storage of the medication: _____

CHECK ONE (1) OF THE FOLLOWING:

_____ Medication may be self-provided by the Student, and the Student is competent to self-provide medication. I, or my designee(s), and the Student have developed a plan for self-provision of the medication(s), the storage of the medication(s), and a plan for reporting and supervision of self-provision of the medication(s), and deem each to be safe and appropriate and, if applicable, authorize the use of hypodermic syringes and needles or similar medical items.

_____ Medication may **NOT** be self-provide by the Student, and the Student is **NOT** competent to self-provide medication. I, or my designee(s), have trained school personnel or approved alternative training as adequate to provide the medication(s), have evaluated the situation, the storage of the medication(s), the general administration plan and, if applicable, the self-administration plan or emergency care plan, and deem each to be safe and appropriate and, if applicable, authorize the use of hypodermic syringes and needles or similar medical items.

Name of Physician and/or Designee

Print or Type

Primary Phone Number

Signature of Physician

Secondary Phone Number