## PARENT'S REQUEST FOR THE ADMINISTRATION OF MEDICATION BY SCHOOL PERSONNEL

I hereby request and give my permission to the principal or his/her delegate (school nurse or other responsible person) to administer the following medication to my child.

Name of Child _____

Name of Drug _____ Dosage _____ Route _____

at the following time(s) _____

Date _____ _____

Signature of Parent or Guardian

Taken from: Montgomery County Health Association Guidelines

**PHYSICIAN'S REQUEST FOR THE ADMINISTRATION OF MEDICATION BY SCHOOL PERSONNEL**

_____ is under my care and should receive
Name of Student

_____ at the following times _____
Name of Drug, Dosage, Route

Specific instructions for administration _____

Possible side effects to watch for _____

Expiration date of this request _____

Date _____ _____
Physician's Signature

_____
Physician's Phone Number

## SELF-MEDICATION FOR ASTHMA INHALERS AUTHORIZATION FORM

Student Name: _____ Date: _____

Address: _____

_____

Medication Name: _____

Dosage: _____

Date the administration is to begin: _____

Date the administration is to cease: _____

Adverse reactions that should be reported to the physician: _____

_____

Adverse reactions for unauthorized user: _____

_____

Procedure to follow in the event that medication does not produce the expected relief from student's asthma attack: _____

_____

_____

Other special instructions: _____

_____

**Physician and parent/guardian names, signatures, and emergency phone numbers:**

Physician name: _____ Phone: _____

Signature: _____ Date: _____

Parent/Guardian Name: _____ Phone: (Work) _____

(Home) _____

(Other) _____

Signature: _____ Date: _____

Copies must be provided to Principal