Triway Local Schools
MEDICATION REQUEST FORM

To be completed by Prescribing Physician or authorized Prescribing Healthcare Provider

Student Name____Age________Date of birth_______________

Grade_________________Teacher______________________________School Year______________________

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Name of Medication Dosage Route

At the following time(s)____

Reason for taking this medication____

Date administration is to begin______________________________end: ___________________

Severe reactions that should be reported to the prescriber: _____________________________

Special storage requirements for this medication____

Special instructions for administering this medication_____________________________________

If applicable: This student received instruction in the use of the above inhaler by my trained staff or myself. It is my recommendation that this student carry their inhaler on their person at all times. Yes No (Circle one)

If applicable: This student received instruction in the use of the above EpiPen by my trained staff or myself. It is my recommendation that this student carry their EpiPen on their person at all times. Yes No (Circle one)

Procedure to follow in the event that the asthma or EpiPen medication above does not produce the expected relief:

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***Physician/Authorized Healthcare Prescribing Signature__________________________________

Date

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Printed Name Address Phone #

I hereby request and give permission to the school nurse, the principal, or the principal's designee, to administer the prescribed medication listed above to my child as instructed by the physician or authorized healthcare provider with prescriptive authority. My child has taken this medication under my supervision and has had no negative side effects. If applicable, my child may carry his/her inhaler or EpiPen as prescribed by physician on his/her person during school or school related activities as stated above. My child and I are aware of the protocols and safety issues at school.

All medication must be brought to the school in the original container as dispensed by the authorized healthcare provider, physician or pharmacist, clearly labeled. Ask the pharmacist to give you 2 containers if necessary. Send only the amount of medication that will be administered during school hours or school sponsored activities. Medications will be kept in the school clinic/office or other secure storage area.

If any revisions to the above plan or prescriber's statement occur, a written revised prescriber's statement must be submitted to the school nurse, the principal or the principal's designee. It is understood that it is the student's responsibility to seek the medication at the proper location and time unless s/he is physically or mentally unable to do so.

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Signature of Parent/Guardian Phone (Home/Work/Cell) Date

Date received at school: ______________________________Initials___________

THS fax 330 262-2620 TJH fax 330 264-6025 Shreve fax 330 567-9107 WTWP fax 330 263-7078 Franklin fax 330 263-7057