PHYSICIAN'S REQUEST FOR PROVISION OF PRESCRIPTION MEDICATION AT SCHOOL

NORRIS SCHOOL DISTRICT #160, 25211 S. 68TH St., Firth, NE 68358

The student, whose name is: ____, is under my care for the

following condition: ____________________________________and must take medication which I have

prescribed during the school day. The intended purpose of this medication can be described as:

____.

My prescription for the school day is as follows: (Please include medication name, dose, route, and frequency at school)

The duration of this medication therapy is: _____for the current school year.

_____for this time: (___________________________________)

Instructions for storage of this medication:

Instructions for reporting adverse reactions:

Any other instructions:

☐ This student will be able to self-provide this medication. The parent/guardians, student, and I have discussed how to use this medication correctly, store the medication, and report the effects of the medication to me and to the school.
If applicable, I also authorize the use of syringes or similar medical items.

☐ This student cannot self-provide this medication. I, or my designee, have trained school personnel or approved alternative training as adequate to provide this medication. The plan for administration is appropriate and safe. As applicable, syringes an other similar medical items can be used.

____/_________________________________

PHYSICIAN OR PRESCRIBER'S SIGNATURE DATE

CLINIC NAME OR STAMP:

Updated May 2006