MEDICATION REQUEST/CONSENT FORM

Martin Luther Academy (8/10)

Medications are to be administered at home whenever possible. If it is necessary for a student to receive medications at school, all appropriate portions of this form must be completed before medication can be given at school. One form is required for EACH medication.

To Be Completed by Parent

STUDENT: _____ SCHOOL: _____ GRADE: _____

ADDRESS: _____ PHONE: _____/_____/_____ BIRTHDATE: ____/____/____

PHYSICIAN: _____ ADDRESS: _____ PHONE: ____/____/____

MEDICATION / PROCEDURE:

Name of medication/procedure: _____

Reason for medication/procedure (diagnosis): _____

Time(s) to be given at school: _____ (Dates to be Given) From:_____ To:_____

Dose at School: _____ Route: Mouth _____ Other Route _____
Injected _____ Inhaled _____

If medication is to be given on an as needed basis (PRN), state conditions under which medication is to be given:
_____

How soon can administration of PRN medication be repeated? : _____

Any additional directions? : _____

Precautions/Unfavorable Reactions: _____

PARENT/GUARDIAN CONSENT: (complete for all Medication/Procedures at school)

- I request and authorize that this medication be administered at school by school personnel.
- I will supply medication in its original, updated, properly labeled container. (Request extra bottle from Pharmacist).
- This order is in effect for this school year unless otherwise indicated.
- I will obtain a new physician's order and notify the school in writing of any changes.
- I authorize school personnel to exchange information verbally or in writing with my child's physician regarding this medication or the conditions for which it is prescribed.
- I further understand that parent/guardian/responsible adult should deliver all medication to the school.
- I understand that non-medically trained school personnel will give medication.
- I agree to hold MLA, its employees and agents who are acting within the scope of their duties harmless in any and all claims arising from the administration of this medication at school.
- My signature indicates that I have fully read and understand the above information.
- ASTHMA INHALERS AND EPI PENS ONLY: This student is capable of self-administration and may carry inhaler or EPI pen and self-administer at school. **YES _____ NO _____**

_____ ____/____/____ ____/____/____ ____/____/____

Signature of Parent/Legal Guardian ***Home Phone or Cell*** ***Business Phone*** ***Date***

PHYSICIAN ORDER: (complete for all prescription medication and all procedures)

The above medication/procedure is to be administered/performed during the school day in accordance with the above instructions and agreements. I agree to accept communication about student/medication/procedure and understand non-medically trained school personnel will give medication. Please contact me if any of the following symptoms occur:

_____

ASTHMA INHALERS AND EPI PENS ONLY: This student and his/her parents/guardians have been instructed in self-administration and student may carry inhaler or EPI pen and self-administer at school. **YES _____ NO _____**

_____ _____/_____/_____

Physician's Signature *Date*

_____ _____ _____-_____-_____

Print Name *Address* *Phone*