FLEETWOOD AREA SCHOOL DISTRICT

Request to Administer Prescription or Non-Formulary Medications

TO: School Nurse of (circle one) Middle School**High School**Richmond Elementary** Willow Creek Elementary**Andrew Maier Elementary **FROM:** (*PRINT doctor's name and address OR stamp name, address, and phone below*) Phone STUDENT_____Grade__DOB____ DIAGNOSIS MEDICATION (list one per form) DOSE_____TIME TO ADMINISTER____ ROUTE of ADMINISTRATION: orally inhalation pulmo-aide nasally IM injection____ location____ SQ injection___ location____ Eyes: left___ right__ both__ Other(specify)_____ The student is excused from these activities while taking this medication: driving physical education use of power tools other____ I authorize the administration of this medication to the above-named student in the manner described above. PHYSICIAN SIGNATURE______date_____ As parent/guardian, I release the school from any and all liability for damages my child may suffer as a result of this request. PARENT SIGNATURE date FOR STUDENTS WHO HAVE BEEN DIAGNOSED AS ASTHMATIC, DIABETIC*, OR SEVERELY ALLERGIC I grant medical approval and permission for the above-named student to carry and to

I grant medical approval and permission for the above-named student to carry and to <u>self-administer</u> the (circle one) inhaler/Epi-Pen/glucagon/glucose tablets described above. This student has received instruction and has demonstrated correct technique in self-administration.

PHYSICIAN SIGNATUREdate

^{*}Diabetics must report to the Health Room for supervision of testing and/or insulin administration. Insulin and any syringes or injection equipment, except insulin pumps, must be kept in the Health Room.

Medication, dose, time to administer:												
	on, dose, time	on, dose, time to admir	on, dose, time to administer:									

initial	signature	
initial	signature	
initial	signature	
initial	signature	