HOLY TRINITY EPISCOPAL DAY SCHOOL
PARENT REQUEST TO ADMINISTER MEDICATION AT SCHOOL
AND PHYSICIAN ORDER FORM

Part 1-For Completion by Parent/Guardian

Name of Student: ______________________________ **D.O.B:** ____/____/____

Name of School: ______________________________ **Grade:** _______ **School Year:** _____

In order for my child to receive medication in school, I agree to the following:

- All prescription and non-prescription medication will have a physician's signed order fully completed for each school year.
- The prescription medication will be in a container labeled by the pharmacist or physician with:

Name of child	Name of medication	Dosage, route and time of administration
Name of physician	Prescription date and expiration date	Conditions for proper storage

- The non-prescription medication will be in the original sealed container with the label intact. Student's name will be put on the container in a position that does not obscure the label.
- The medication will be brought to school by an adult. Students are not to handle medications.
- The physician will be called if a question arises about my child's medication.
- The first dose of this medication (except for Epi-Pen) has been given without problems.

Having read the above conditions, I request Holy Trinity Episcopal Day School personnel administer the medication as prescribed by the physician below. I certify that I have legal authority to consent to medical treatment for the student named above, including the administration of medication at school.

Signature of Parent/Guardian ______________________________ **Date:** ______________

Relationship to student: ____________________

Phone #: (H): ____________________ (W): ____________________ Other: ____________________

Address: ____

Part 2-Physician's Signed Order for Medication at School
One Medication Per Form

Diagnosis: ____

Name of Medication: ____

Dosage: ________________________________**(mg, ml, ml/tsp, # of puffs)**

Route: ______________ **Time of Administration at School:** _______ ☐ **Lunchtime**

Please list any specific precautions personnel should be aware of or any unusual side effects that might be observed:
____

Please list special requirements such as "take with food": ______________________________

Services should begin (Date) ________________ **and terminate (Date)** ______________

For Middle School students (Grades 5-8) only who use an inhaler:
____ It has been determined that this MS student is able to self-administer and carry inhalant medication and has been trained in its use including knowing when the medication is to be used.
____This MS student should not self-administer inhalant medication.

Signature of Physician: ______________________________**Physician's Name (Printed):** _______
(original, no stamp)

Address: ____

Telephone Number: ______________________________ **Date:** ____________________