The Westview School
Health Services
2024-2025

REQUEST FOR ADMINISTRATION OF MEDICATION AT SCHOOL

This form must be filled out completely to allow the School Nurse and /or other trained staff assigned by the Principal, to administer medication to a student. A new medication form must be completed at the beginning of each school year for each prescription or non-prescription medication, and each time there is a change in the medication's administration instructions.

In accordance with school policy, only medications authorized by a healthcare provider will be administered.

* Prescription medications must be in their original container, properly labeled by a pharmacist.
* Non-prescription medications must be in unopened, original container, with the dosage instructions on the original label, clearly legible. These medications should be sealed in a clear, plastic bag labeled with the student's name.
* **ALL** medications are to be dropped off with the School Nurse. Medications should not be sent in backpacks/ lunchboxes or left with front office staff or teachers.

Student's Name: _____Sex: _____

Date of Birth: _____ / _____ / _____ Teacher/ Homeroom: _____

This section is to be filled out by the healthcare provider:

Indication: _____ Duration: _____ /_____ /_____ to _____/ _____/ _____

Medication Name: _____
(Strength)

Dosage: _____Route: _____Frequency: _____

Possible Side Effects: _____

Known Allergies? YES NO If Yes, please list: _____

Does student take any other medications at school or at home? YES NO If yes, please list: _____

_____

This is permission to give medication to my child named above, as requested by the physician. I understand that I am giving consent for the School Nurse to discuss any concerns regarding this medication with the healthcare provider whose signature appears on this document, in order to monitor the healthcare needs of my child.

_____
(Parent/ Guardian Signature)

_____
(Parent/ Guardian Printed Name)

_____
(Telephone)

_____
(Date)

_____
(Physician/ Advanced Practice Nurse Signature)

_____
(Physician/ Advance Practice Nurse Printed Name)

_____
(Telephone)

_____
(Date)

FACILITY USE ONLY

Reviewed by: _____
(School RN Signature)

Date: _____ Time: _____