REQUEST FOR ADMINISTRATION OF MEDICATION

Childs Name _____ School: _____
Date of Birth _____ Grade: _____
School Nurse _____ Fax #: _____

To be completed by the school nurse/parent and faxed to the Health Care Provider (HCP) for signature – OR – to be completed by the HCP at office when prescribing medication and faxed or brought back to the school.

DIAGNOSIS: _____

RX (DOSAGE/FREQUENCY/ROUTE) _____

REPORTABLE ADVERSE REACTIONS/SIDE EFFECTS _____

BEGINNING DATE _____ **ENDING DATE** _____

LIST OTHER MEDICATIONS CURRENTLY BEING TAKEN _____

NAME OF PRESCRIBING HEALTH CARE PROVIDER _____

HCP's SIGNATURE _____ **DATE** _____

HCP's PHONE NUMBER _____ **FAX** _____

I request that the Principal or his/her designee administer the medication as directed above. I authorize the release of information between the school and Health Care Provider, and the HCP and school regarding my child's diagnosis and medication per HIPAA.

Sign before faxing to Health Care Provider.

_____ _____ _____ _____
Parent/Guardian Signature **Date** **Phone** **Emergency #**

INHALTER/EPI-PEN EXCEPTION
My child meets Wyoming state statute §21-4-310 conditions for self-administration of life-saving drugs, and is responsible and **capable** of self-administration. *Note: Child must be able to tell time to use an inhaler correctly.*

_____ _____ _____ _____
Parent/Guardian Signature **Date** **Phone** **Emergency #**

PARENT PLEASE NOTE: STUDENT MEDICATION MUST BE IN THE PRESCRIPTION OR MANUFACTURER'S ORIGINAL CONTAINER.

Adopted: 04/08/19