

# ALPHA OMEGA ACADEMY REQUEST FOR MEDICATION AT SCHOOL

Student Name \_\_\_\_\_ DOB \_\_\_\_\_

**Medication is ordered to be given to a student at school only when necessary.** Whenever possible, the parent and physician are urged to design a schedule for giving medication outside of school hours.

The school accepts no responsibility for untoward reactions when the medication is dispensed in accordance with the physician's directions.

Medication, dose, number of times to be given daily:

\_\_\_\_\_

Take Medication: \_\_by mouth \_\_via inhaler \_\_topical \_\_injection \_\_other \_\_\_\_\_

Reason for Medication: \_\_\_\_\_

Time(s) to be given: \_\_\_ Lunch (or) \_\_\_\_\_ Scheduled time (or) \_\_\_ As Needed

Duration without subsequent order: Start (date) \_\_\_\_\_ End (date) \_\_\_\_\_

Medication Expiration Date: \_\_\_\_\_

Other medications student is taking: \_\_\_\_\_

## Parent/Guardian's Permission:

I request that the school nurse or designated staff member be permitted to dispense as described the above medication to my child.

The medication is to be brought to the nurse by me in the original container, labeled with my child's name.

If notified by school personnel that medication remains after the course of treatment, **I will collect the medication from the school within five school days or understand that it will be destroyed.**

Parent/Guardian Signature: \_\_\_\_\_ Date: \_\_\_\_\_

Phone: \_\_\_\_\_

**Over-the-counter medications that must be given during school hours may be kept and/or administered for up to five consecutive school days without a physician's order. If your child will require an OTC medication to be kept at school for a longer period, please have this form completed by your child's physician.**

Health Care Provider's Signature: \_\_\_\_\_ Date: \_\_\_\_\_

Phone: \_\_\_\_\_ Fax: \_\_\_\_\_