RETURN TO SCHOOL NURSE

SCHOOL ADMINISTRATION OF MEDICATION

Student Name_____
Address _____
_____
Student's School _____
Student's DOB_____

Physician's Name_____
Address _____
_____
Phone_____

This form must be filled out each school year for any student who is taking prescribed medication that must be administered during school hours. This applies to any prescription medication including those needed for a life threatening situation. **Both physician and parents' signatures are required at the bottom of the form.** If any changes in medication or dosage take place, a new form must be completed. ALL MEDICATIONS MUST BE IN THE ORIGINAL CONTAINER. This form adheres to WV State Board of Education Policy (2422-8):Medication Administration.

Medication:_____ Diagnosis:_____

Dosage and Time_____ Route/Method:_____

Possible Side Effects:_____

Allergies &/or Other Instructions:

_____

For **ASTHMA** students: Student to carry inhaler at all times? **YES/NO**
Student to self administer inhaler
after passing assessment by school nurse? **YES/NO**

For **ANAPHYLACTIC REACTIONS**: to BEE STINGS/ FOOD ALLERGY_____/OTHER_____
Medication:

Benadryl 12.5mg	Epi-Pen Injection	Student may carry Epi-pen at all times.	**YES/NO**
Benadryl 25mg	Epi-pen Jr. Injection	Second Epi-pen to be kept at school.	**YES/NO**
Benadryl 50mg	Epi-pen Twinjet Injection	***if YES-adminster_____minutes from 1st dose.**	

For **SEIZURE** students:
Medication:
Diastat dose_____ After _____minutes of seizure activity.
Diastat may be administered by unlicensed/trained school personnel. **YES/NO**

For **DIABETIC** students: Student may carry diabetic supplies at all times. **YES/NO**

Physician's Signature_____ Date_____

Parental Signature Approving the Administration of above ordered Medication and Release of Liability. I, the parent/guardian of _____, enrolled at _____ realizing the importance of administering medication to my child as prescribed by the student's physician, do hereby agree to relieve designated school personnel of any liability from any potential ill effects as a result of their giving or injecting my child with the medication prescribed by the child's physician. I have discussed this with my physician and realize its ramifications and thoroughly understand the meanings of these statements.

Parent/Guardian Signature_____ Date_____

School Nurse/Designee_____ Date_____