FELL CHARTER SCHOOL
School Health Services

PHYSICIAN/PARENT'S
REQUEST FOR MEDICATION ADMINISTRATION

Dear Physician:

Please fill out the form below for your patient to receive medications during school hours. This form may be faxed to the School Nurse at 570-282-0930. Thank you.

Student Name: _____ *DOB:* _____ *Grade:* _____
Diagnosis: _____

Name of Medication: _____
Dosage: _____
Route of Administration: _____
Time to be Given: _____
Possible Side Effects: _____
Duration of Medication Order: _____

If PRN, describe indications: _____
_____

Possible side effects: _____
_____

Contraindications: _____

Curtailment of specific school activity (gym, recess): _____

Is student capable of self-administration supervised by a responsible adult if the nurse is not available? _____

Is student able to carry asthma medication on his/her person and correctly self-administer this medication within guidelines of school medication policy?

_____

Special instructions: _____
_____

Date: _____ **Physician Signature:** _____
(Must be original signature, no stamps will be accepted)

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I hereby release the Fell Charter School and its employees from any liability for any injury that may result out of the administration of the above medication in accordance with this request.

Parent/Guardian Signature: _____ **Date:** _____