# Columbus Academy
## Request for Assistance in the Self-Administration of Prescribed Medication

Some students are able to attend school only through the effective use of medication. If possible, all medication should be given under the supervision of parent/guardian outside of school hours. When this is not possible, school personnel may give prescribed medication when complete documentation of all information as requested from physician and parent/guardian is received and the medication is delivered to the school by the parent/guardian in the original labeled container in which it was dispensed by the physician or licensed pharmacist. The container needs to have a pharmacist's label with the following information: student name; physician name; date; pharmacy name and telephone; name of medication; prescribed dosage and frequency; and special handling and storage directions.

| Student Name | School & Grade |
|---|---|
| Address | Allergies |
| Home Telephone | Parent/Guard.<br>Daytime Tel. |

**Information from Prescribing Physician**: The following medication needs to be administered **during the school hours** and is being prescribed for that time. I understand that unlicensed school personnel will be assisting the child with the self-administration of this medication.

| | |
|---|---|
| Name & dose of the drug | |
| Amount to be administered | |
| School times or intervals for administration | |
| Route of administration | |
| If p.r.n., give specific indications. For asthma, provide peak flow meter and acceptable range. | |
| Adverse reactions to report to physician | |
| Other special instructions. Must document training & conditions if allowed to carry inhaler. | |

| Date to begin: | Date to end: |
|---|---|

| Print Physician Name<br>Address<br>Telephone | Physician Signature |
|---|---|

**Parent or Guardian Information**

I request that the drug prescribed by the physician be administered to the student. I agree to submit in writing a revised physician's statement in the event that any of the required information should change. I give permission for the principal or school nurse to contact the physician regarding the administration of this medication in the school setting. I agree to deliver the needed medication to the school in the proper container. I agree to pick up medication within 3 days of termination of administration or end of school year, or school staff will dispose of medication.

Parent/Guardian Name Signature Date