WOOSTER CITY SCHOOL DISTRICT *Form 5330 - A*

PRESCRIPTION MEDICATION REQUEST FORM

To be completed by the Parent/Guardian

Student Name____ School ____________________

School Year_______________ Grade/Teacher______________________ Date of Birth_____________

I hereby request and give permission to the school nurse, the principal, or the principal's designee, to administer the prescribed medication listed below to my child as instructed by the physician or authorizer healthcare provider with prescriptive authority. My child has taken this medication under my supervision and has had no negative side effects.

All medication must be brought to the school in the original container as dispensed by the authorized healthcare provider, physician or pharmacist, clearly labeled. Ask the pharmacist to give you 2 containers if necessary. Send only the amount of medication that will be administered during school hours or school sponsored activities. Medications will be kept in the school clinic/office or other secure storage area.

If <u>any</u> revisions to the above plan or prescriber's statement occur, a written revised prescriber's statement must be submitted to the school nurse, the principal or the principal's designee. It is understood that it is the student's responsibility to seek the medication at the proper location and time unless s/he is physically or mentally unable to do so.

______________________________ ____________ ____________ /__________ /__________

Parent/Guardian Signature Date Phone number (home/work/cell)

To be completed by Prescribing Physician or Authorized Prescribing Healthcare Provider

____

Name of Medication Dosage Route

At the following time(s)____

Date administration of this medication is to begin________________________ end: _______________

Severe reactions that should be reported to the prescriber:_____________________________________

____

List special instructions for administering this medication: ______________________________________

____

List special storage requirements or sterile conditions needed for this medication: ____________________

____

Should a change in any of the above information occur, a revised written prescriber statement must be submitted to the school nurse, principal or the principal's designee.

____

Physician/Authorized Prescribing Healthcare Provider Signature Phone # Date

____

Printed Name

School use: Date received: _______________ Initials:_________

School Nurse notified by: (place date in one box) E-mail_____ Phone _____ Mailbox _____ In person_______

School Nurse Signature:____ Date_______________ 5/03