SUNRISE SCHOOL DIVISION

Request for Medication Administration

Sunrise School Division recognizes that some students may require medication during the school day. Where the administration of this medication is not possible by parent, guardian, or appropriate medical authority; is necessary during school hours; and the student is not able to manage this medication administration, the following Request for Medication Administration must be completed in its entirety.

Requests to administer medication apply to prescription and over the counter medications (if recommended by a physician and accompanied by original pharmacy label and/or written physician instructions). For a school to agree to administer medications, parents or guardians must provide all required information to the school and meet all conditions as established by the Division (see attached list). A new request is required for each school year and for changes in medication. When a child requires a medication for more than 14 days, an Individual Health Care Plan (IHCP) is required, contact the URIS Nurse for the development of an IHCP.

To be completed by Parent(s) or Guardian(s).

1. I request that medication be administered to _____
(name of student)

   Date of Birth (d/m/y) _____ Personal Health Info Number _____

   Address: _____ Home Phone Number: _____

   _____

2. Name of Parent(s) / Guardian(s): _____

   Address: _____ Work Phone Number: _____

   _____ Home Phone Number: _____

3. Name of prescribing physician: _____

   Office Address: _____ Phone Number: _____

   _____

4. Name of dispensing pharmacy: _____

   Address: _____ Phone Number: _____

5. Name of medication(s): _____

   Date prescription filled: _____

6. Reason(s) for medication(s): _____

   _____

7. Dosage and method of administration: _____

_____

8. Time of administration at school: _____
9. State date of medication (d/m/y): _____
10. Stop date of medication (d/m/y): _____
11. I confirm that the first dose of medication(s) was administered at home or hospital.
    (Please initial) _____
12. I confirm that the first dose of medication(s) was well tolerated by this child.
    (Please initial) _____
13. Storage requirements (if any): _____
14. Description of side effects: _____
    _____
15. Response to side effects: _____
16. I certify that the information provided is accurate:

_____ _____

Signature of Parent(s) or Guardian(s) **Date**

Conditions for Acceptance of Medication Administration

1) Completed Request for Medication Administration
2) Medication delivered to school by a responsible adult
3) Prescription medication is in an original pharmacy labeled container which identifies:
    a. Name of child
    b. Name of prescribing physician
    c. Name of medication
    d. Dose
    e. Frequency and route of administration
    f. Name of pharmacy
    g. Date the prescription was filled
4) Label is on the medication and not just the package
5) Over-the-counter medication that is recommended by a physician is accompanied by an original pharmacy label with administration instruction and/or clearly written instruction from a physician. Measuring instruments are provided.

If requested, pharmacies will provide **two original pharmacy labeled containers**. One container may be used exclusively in the school. This is recommended.

_____ _____

Signature of Principal or Designate **Date**