MEDICATION ADMINISTRATION REQUEST
2021-2022

(To Be Completed by Parent/Guardian)

(This form is for students who require prescription medications during school, including the use of epi-pens, inhalers, and insulin)

NAME OF STUDENT: _____ GRADE: _____ Student # _____

PHYSICIAN / PHYSICIAN'S ASSISTANT / NURSE PRACTITIONER: _____
(For Prescription Medication only)

_____

NAME OF MEDICATION: _____

DOSAGE AND TIME OF ADMINISTRATION AT SCHOOL: _____

BEGINNING DATE: _____ ENDING DATE: _____

I, _____ , parent/legal guardian of _____ , request that designated school personnel, under the supervision of the director/assistant director, administer the above medication to _____ during the times indicated. I agree to furnish said medication in the original container with the label intact. I understand and accept that the Appomattox Regional Governor's School, its employees, agents or designees are not responsible for any effects of the medication administered when it is administered as directed above.

I also agree to pick up any unused medication from the main office at the end of the school year, no later than the last school working day in June. Failure to do so will result in the medication being disposed of by appropriate school personnel after that date.

_____ _____
Parent/Guardian Signature Date

_____ _____
Physician Signature Date

ASTHMATIC / DIABETIC / SEVERE ALLERGY <u>ONLY</u>

I request that my child carry and self-administer the above medication. I verify that he/she is capable and responsible for self-administering the medication. Self-administration should be:

☐ With Assistance ☐ Without Assistance

I will provide physician's/physician's assistant/nurse practitioner's authorization for self-administration.

_____ _____
Parent/Guardian Signature Date