Green Meadows
Robert Bassett
Principal

Jack L. Boyd Outdoor School

Request for Administration of Medication **(side 1 of 2)**

Steven E. Gomes, Ed.D.
Superintendent

Student Name: _____ Birthdate:_____ ☐ Male

School: _____ Grade: _____ Teacher: _____ ☐ Female

Prescriptions and nonprescription drugs require Parent and Physician signatures on each side of this form used, as well as on any added copies needed. Parents, please make copies if more medicines are required.

TO BE COMPLETED BY AUTHORIZED HEALTH CARE PROVIDER

Medication 1	**Medication 2**
Medication Name: _____	Medication Name: _____
Strength (mg, ml, mcg):_____	Strength (mg, ml, mcg):_____
Dose (#of tabs, puffs, etc.): _____	Dose (#of tabs, puffs, etc.): _____
Diagnosis: _____	Diagnosis: _____
Method of Administration: _____	Method of Administration:_____
Time of Administration (circle if appropriate):	Time of Administration (circle if appropriate):
8:45am 1:00pm 6:30pm 9:30pm	8:45am 1:00pm 6:30pm 9:30pm
Other: _____	Other:_____
Start: ☐ Immediate ☐ Other Date:_____	Start: ☐ Immediate ☐ Other Date: _____
Stop: ☐ Immediate ☐ Other Date:_____	Stop: ☐ Immediate ☐ Other Date: _____
PRN (prescribe as needed):	**PRN** (prescribe as needed):
Symptoms: _____	Symptoms:_____
Frequency: _____	Frequency:_____
Initiate medical referral: _____	Initiate medical referral: _____
☐ For episodic/emergency events only	☐ For episodic/emergency events only
Reason for Medication:_____	Reason for Medication: _____
Restrictions and/or important side effects:	Restrictions and/or important side effects:
☐ None anticipated	☐ None anticipated
☐ Yes (please describe): _____	☐ Yes (please describe): _____
Special storage requirements:	Special storage requirements:
☐ None ☐ Refrigerate ☐ Other _____	☐ None ☐ Refrigerate ☐ Other_____
Comments: _____	Comments: _____

Health Care Provider Signature: _____ Date:_____

Health Care Provider Name (PRINT): _____ Phone:_____

Health Care Provider Address: _____

TO BE COMPLETED BY PARENT OR GUARDIAN
PARENTAL CONSENT FOR MEDICATION TO BE ADMINISTERED BY SCHOOL PERSONNEL

Parent(s)/guardian(s) of _____request that the medicine(s) above be administered by school nurse or a member of the school staff if the school nurse is not available. I consent to allow disclosure of identifiable health information from the health care provider to the school nurse or other designated school personnel. **Medication must be furnished by the parent or guardian in its original pharmacy or store-labeled container.**

Parent/Guardian Signature: _____ Date:_____

Parent/Guardian Name (PRINT): _____ Phone:_____

Address:_____