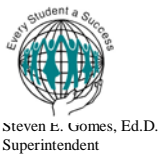




# Jack L. Boyd Outdoor School

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



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): 8:45am    1:00pm    6:30pm    9:30pm Other: _____	Time of Administration (circle if appropriate): 8:45am    1:00pm    6:30pm    9:30pm Other: _____
Start: <input type="checkbox"/> Immediate <input type="checkbox"/> Other Date: _____	Start: <input type="checkbox"/> Immediate <input type="checkbox"/> Other Date: _____
Stop: <input type="checkbox"/> Immediate <input type="checkbox"/> Other Date: _____	Stop: <input type="checkbox"/> Immediate <input type="checkbox"/> Other Date: _____
<b>PRN</b> (prescribe as needed): Symptoms: _____ Frequency: _____ Initiate medical referral: _____ <input type="checkbox"/> For episodic/emergency events only Reason for Medication: _____	<b>PRN</b> (prescribe as needed): Symptoms: _____ Frequency: _____ Initiate medical referral: _____ <input type="checkbox"/> For episodic/emergency events only Reason for Medication: _____
Restrictions and/or important side effects: <input type="checkbox"/> None anticipated <input type="checkbox"/> Yes (please describe): _____	Restrictions and/or important side effects: <input type="checkbox"/> None anticipated <input type="checkbox"/> Yes (please describe): _____
Special storage requirements: <input type="checkbox"/> None <input type="checkbox"/> Refrigerate <input type="checkbox"/> Other _____	Special storage requirements: <input type="checkbox"/> None <input type="checkbox"/> Refrigerate <input type="checkbox"/> 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: \_\_\_\_\_