

ST. BERNARD-ELMWOOD PLACE CITY SCHOOLS
ADMINISTRATION OF PRESCRIPTION MEDICATION TO STUDENTS
SELF MEDICATION FOR ASTHMA INHALERS
PHYSICIANS REQUEST FORM

Name _____

Address _____

School Year _____

Building _____

Name of Medication (as it appears
on container in which the medication
is stored): _____

Dosage (time or intervals) _____

Date administration of medication
is to begin: _____

Possible adverse reactions
to be reported to physician: _____

Procedure to follow in the event that
the medication does not produce the
expected relief from the student's asthma attack: _____

Special instructions for the
administration or storage of
the medication: _____

Name of Physician: _____

Primary Telephone No: _____

Secondary Telephone No: _____

Signature of Physician

ADMINISTRATION OF PRESCRIPTION MEDICATION TO STUDENTS
SELF MEDICATION FOR ASTHMA INHALERS
PARENTAL AUTHORIZATION AND RELEASE FORM

Student Name _____ Date _____

Address _____

Building of Attendance _____ School Year _____

Medication Name _____

Dosage _____

Date the administration is to begin _____

Date the administration is to cease _____

I hereby request the St. Bernard-Elmwood Place Board of Education, or its authorized representative to administer the above-named medication in accordance with the prescribing physician's instructions and administer the above named medication in accordance with the prescribing physician's instructions and agree to:

1. Submit this request to the person authorized by the Board of Education to receive such request.
2. Make certain the "Physician's Request for the Administration of Prescription Medication by School Personnel" is submitted to the person authorized by the Board of Education to receive such requests.
3. Make sure personally that the medication is received by the person authorized to administer in the container in which it was dispensed by the prescribing physician or licensed pharmacist.
4. Make sure that the container in which the medication is dispensed is marked with the medication name, dosage, interval of dosage, and date after which no administration should be given.
5. Submit a revised statement signed by the physician who prescribed the medication to person designated by the Board of Education to receive requests for administration if any of the information provided by the physician changes.
6. Release the Board of Education of the St. Bernard-Elmwood Place City School District and their designated representative from any liability concerning the giving or non-giving of the medication to the student.

Parent/Guardian Name _____ Phone (w) _____

(h) _____

(other) _____

Signature _____ Date _____