Physician Request Form for Prescription and Non Prescription Medication

Newburg R-II Public School
Phone: 573-762-9653 Ext. 1004
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Part 1: **Must be completed by a Physician/qualified medical provider. Use one form per medication.**

Student:_____Birth date:_____Date:_____

Allergies:_____Diagnosis:_____

Medication (one per form):_____Dose Prescribed:_____

Route:_____Time to be given:_____(must be specific & match medication label)

PRN ORDERS: If you are ordering medication "**AS NEEDED**", please specify under what conditions the child is to take (i.e.pain):

_____

NARCOTICS FOR PAIN MANAGEMENT WILL NOT BE ACCEPTED.

Inhaler/Nebulizer: Medication Name_____Strength/Dose_____
Amount/# of puffs_____ Schedule (at what time)_____
If you are ordering the Inhaler "as needed" please specify under what conditions: (check all that apply)
☐ Shortness of Breath ☐ Coughing ☐ Wheezing ☐ Other_____

The student has been trained and has my permission to self-administer the MDI.
Check One: ☐ Student may carry inhaler **OR** ☐ Inhaler to be kept in clinic

Medication side effects: _____

Physician Authorization

The parent knows of this request and has agreed to provide the supplies needed for the above medication. Should the child manifest any of the above symptoms that may be caused by the medication, I understand that the parent will be contacted and the school health directives relating to emergency care will be followed.

_____
Physician's Name (Print) Physician's Signature Date

_____
License Number Telephone Fax Number

Part 2: **Must be signed by a parent/guardian prior to administration.**

Parent/Guardian Permission

I understand that:

- Medication orders include over-the-counter, are valid for this school year only and need to be renewed at the beginning of each school year.
- Medication including over-the-counter, must be in the original container and labeled to match physician's order for school use including field trips.
- I have the responsibility for supplying medication as needed.
- Medication orders become part of my child's permanent school health record.
- I give permission to the school nurse to share information with appropriate school staff relevant to the prescribed medication administration as he/she determines appropriate for my child's health and safety.
- I may retrieve the medication from the school at any time however the medication will be destroyed if it is not picked up within one week following termination of the order or one day beyond the last day of the school year.

I hereby give permission for my child (named above) to receive medication during school hours administered by the nurse or trained principal designee. I understand the School District undertakes no responsibility for the administration of the medication. This medication has been prescribed by a licensed physician. I hereby release the school district and its agent and employees from any and all liability that may result from my child taking the medication.

_____
Parent/Guardian Name (Print) **Signature** **Date**