Student's Name: _____School: _____ Grade/Teacher: _____

Franklin City Schools

Request for Assistance in the Self-Administration of Medication

Some students are able to attend school only through the effective use of medication. If possible, all medication should be given under the supervision of the parent/guardian outside of school hours. When this is not possible, school personnel may give medication when complete documentation of all information, as requested from physician and parent/guardian is received. The medication must be delivered to the school, by the parent/guardian, in the original labeled container in which it was dispensed. The container needs to have a pharmacist's label with the following information: student's name, physician's name, date, pharmacy's name and telephone number, name of medication, dosage and frequency, and special handling and storage instructions.

Information from Prescribing Physician

Student's Name:	Date of Birth:
Address:	Allergies:
Phone Numbers:	

The following medication needs to be administered during the school hours. I understand that unlicensed school personnel may be assisting the child with the administration of this medication in the event that a licensed nurse is not available.

Name of Medication:	
Dosage, Route & Time or Intervals for administration:	
If PRN, conditions indicating need:	
If allowed to carry inhaler or (Other special instructions, storage of the medication):	
Possible adverse reactions to report to the physician:	
Date to begin administration:	
Date to cease administration:	
Physician's Name, Address & Phone	**Physician Signature**

I request that the medication prescribed by the physician be administered to the student. I agree to submit in writing a revised physician's statement in the event that any of the required information should change. I give permission for the school nurse to contact the physician regarding the administration of this medication in the school setting. I agree to deliver the needed medication to the school in the proper container. I agree to pick up the medication within 3 days of termination of administration or the end of the school year, or the medication will be disposed of by school staff. I agree to release the Board of Education of the Franklin City School District and their designated representative from any liability concerning the giving or non-giving of the medication to my child.

_____ _____ _____ _____

PRINT Parent/Guardian Name | Daytime Phone | **Signature** | Date

_____ _____ _____ _____ _____

Received by: | Date | Quantity Received | Parent Initial | Staff Initial

_____ _____

School Nurse Signature | Date