

**QUAKER VALLEY SCHOOL DISTRICT**  
**Request for Medication Administration in School**

<b>REQUIRED TO BE COMPLETED BY LICENSED PRESCRIBER</b>								
<b>Student Name</b>	<b>Grade</b>							
<b>Medication</b>	<b>#1</b>	<b>#2</b>						
<b>Diagnosis</b>								
<b>Dosage</b>								
<b>Time of Administration</b>								
<b>Length of Administration</b>	Start <span style="margin-left: 150px;">Stop</span>	Start <span style="margin-left: 150px;">Stop</span>						
<b>Reason for Medication</b>								
<b>Administration Instructions</b>								
<b>Side Effects</b>								
<b>Field Trip</b>	Please choose an option below for when a nurse/parent/guardian is unable to attend field trip: ___ Yes, the prescribed dose can be withheld on the day of the field trip. ___ Yes, the time can be adjusted with the parent /guardian to be administered upon return to school ___ No, this medication must be given to the child at the prescribed time.  Explain:							
<b>Competency for Self Administration</b>	I certify that this student has a potentially life- threatening allergy and/or asthma and requires an <b>inhaler</b> or <b>auto injecting epinephrine</b> . This student is competent and has been instructed in the proper method of self -administration of the medication. This student may therefore carry and self -administer his/her inhaler and/or auto injecting epinephrine.  <b>Print Prescriber's Name :</b>							
<b>Signature of Licensed Prescriber</b>	<table style="width: 100%; border: none;"> <tr> <td style="border: none;">Name _____</td> <td style="border: none;">Date _____</td> </tr> <tr> <td colspan="2" style="border: none; text-align: center;">(Not Valid without licensed prescriber signature)</td> </tr> <tr> <td colspan="2" style="border: none;">Phone _____</td> </tr> </table>		Name _____	Date _____	(Not Valid without licensed prescriber signature)		Phone _____	
Name _____	Date _____							
(Not Valid without licensed prescriber signature)								
Phone _____								
<b>ONLY PRESCRIBED MEDICATION CAN BE ADMINISTERED BY THE LICENSED SCHOOL NURSE</b>								
<b>REQUIRED TO BE COMPLETED BY PARENT/GUARDIAN:</b> I give permission for my child to receive the medication as ordered by the licensed prescriber. I also authorize, as needed, the sharing of information related to my child's health condition and this medication between the school nurse and the licensed prescriber of the medication.								
<b>Parent/Guardian Signature</b> _____		<b>Date</b> _____						
(Not Valid without signature)								
<b>Contact Information:</b>								
Parent/Guardian Call 1 <sup>st</sup> _____ Call 2 <sup>nd</sup> _____								
<i>According to Pennsylvania state medication guidelines, medication not picked up by the parent/guardian at the end of the school year will be disposed of. Medications must be picked up within one day after the end of the school year at Quaker Valley - school nurses are not available after that day. Only Epi-pens and inhalers will be sent home with students at the end of the school year, with parent permission.</i>								