Gustine Joint Unified School District **School Year: 2019-2020**

Please return completed form to the School Site Health Office with medication

REQUEST FOR ADMINISTRATION OF MEDICATION AT SCHOOL

Student:_____ Birth Date:_____

School:_____ Teacher:_____ Grade:_____

TO BE COMPLETED BY AUTHORIZED HEALTH CARE PROVIDER

Medication name:_____ Strength(mg, ml, mcg):_____

Dose (# of tabs, puffs, etc):_____ Method of Administration:_____

Time of Administration (24hr period): AM _____ _____ PM _____ _____ _____

Reason for Medication:_____

Special storage requirement (refrigerate or none):_____

Start Date:_____ Stop Date:_____(end of year or other date)

Restrictions and/or important side effects: _____ none anticipated___yes please describe:

_____

REQUEST FOR SELF-ADMINISTRATION OF INHALERS AND EPIPENS

(Only for auto-injectable epinephrine or inhaled asthma medication)

This student is both capable and responsible for self-administering auto-injectable epinephrine or inhaled asthma medication: _____Unsupervised _____Supervised/need assistance

Health Care Provider Name:_____ **NPI#**_____

Health Care Provider's Signature:_____ **Date:**_____

Address:_____ Phone #:(____)_____

TO BE COMPLETED BY PARENT OR GUARDIAN

PARENT/GUARDIAN CONSENT FOR MEDICATION TO BE ADMINISTERED BY SCHOOL PERSONNEL and/or CONSENT FOR SELF-ADMINISTRATION OF MEDICATION (inhalers or epipens only).

Parent(s)/ Guardian(s) of _____, request that medicine be administered by the 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. I will notify the school if the mediation has changed or is no longer needed. Medication will be furnished in its pharmacy labeled container.

Parent/Guardian Signature: **Date:**

Emergency Contact: