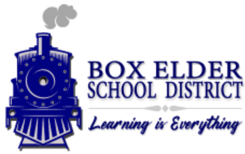

Box Elder School District
Steven E. Carlsen, Superintendent
O. Jay & Tamra Call Education Center
960 South Main Street
Brigham City, Utah 84302

REQUEST FOR ADMINISTRATION OF MEDICATION
PRESCRIPTION

STUDENT INFORMATION

Student Name: ______________________________ Birth date: __________________

School/Location: ____________________________ Grade/Teacher: _______________

Parent/Guardian Name: _______________________ Phone Number: _______________

MEDICATION INFORMATION

Prescribing Physician: _________________________ Phone Number: _______________

Medication Name: ______________________________ Dosage: ____________________

Route Medication is Given: ______________________ Time Given: ________________

Possible Side Effects: ____

PARENT/GUARDIAN REQUEST AND AUTHORIZATION

I, the undersigned, request and authorize the school nurse, secretary, or alternate school personnel to administer medication as prescribed by the student's physician. I request and authorize the release of information between the school, the school nurse, and prescribing physician pertinent to the student's condition. I understand that a new request is to be processed should there be a change in authorization or physician's orders.

____________________________________ ____________________________
Signature of parent or legal guardian *Date*

PHYSICIAN S SIGNED STATEMENT

It is medically necessary for ______________________ to be given the following medication at school:

Medication: __________________ Dosage: _______________ Time: ____________

____________________________________ ____________________________
Physician Signature (must have signature or a copy of the prescription attached) *Date*

SCHOOL NURSE SIGNATURE

Form reviewed and complete by ________________________, RN, Box Elder School District Nurse.

____________________________________ ____________________________
School Nurse Signature *Date*

Office of the School Nurses
Phone: 435-734-4800
Fax: 435-734-4833
Web: www.nurses.besd.net