

Physician Request for Administration of Medication During School Hours

It is the policy of the Wissahickon School District/Gwynedd Mercy Academy High School to request that medication be given before or after school hours whenever possible. If it is ***essential*** that the student receive medication during school hours, please have your licensed physician complete the following request. Once completed by your physician, sign and submit to the School Nurse.

Student Name: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Grade: \_\_\_\_\_\_\_\_\_\_\_\_\_

Diagnosis: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Reason for medication to be given in school: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Name of medication: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

\*Dosage and Route of Medication: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Total dosage in 24 hours: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Time to be given: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Date start: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Date end: \_\_\_\_\_\_\_\_\_\_\_\_

Possible side effects/special consideration: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Treatment of side effects/actions to be taken: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Other prescribed medications student is taking outside of school hours: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

FOR DAILY MEDICATIONS ONLY:

In the event of a field trip, the student may, per instruction from parent/guardian:

* Omit his/her medication: 🞏 Yes 🞏 No Physician Initials: \_\_\_\_\_\_\_\_\_
* Receive upon return to school: 🞏 Yes 🞏 No Physician Initials: \_\_\_\_\_\_\_\_\_

In the event the daily dose is not taken at home, per instruction from parent/guardian:

* Administer at school: 🞏 Yes 🞏 No Physician Initials: \_\_\_\_\_\_\_\_\_\_\_

Physician Signature: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_Date: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Phone: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Parent/Guardian Signature: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Date: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Phone: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

*I authorize the School Nurse to communicate with my child’s physician and my physician to reply, as needed, regarding this medication/treatment and/or my child’s response.*

\*Any medications to be given during school hours must be delivered directly to the School Nurse. The medication must be brought to the school in the original pharmaceutical dispensed and properly labeled container. All controlled medications must be delivered to the School Nurse by an adult, counted, and recorded on the student’s medication log. If the medication or treatment prescribed exceeds or differs from that approved by the FDA or manufacturers’ recommendations, the physician or parent/guardian will be required to submit written detail to the School Nurse.

M4 (4/20)