

THE SCHOOL DISTRICT OF PHILADELPHIA
FAMILY RESOURCE NETWORK

REQUEST FOR ADMINISTRATION OF MEDICATION or USE OF SUCTION, OXYGEN or OTHER EQUIPMENT IN SCHOOL

(PLEASE SEE MESSAGE TO PHYSICIAN AND PARENT ON BACK OF FORM)

PHYSICIAN, PLEASE NOTE:

*Please: Fill in all of the spaces. Missing information will cause the form to be returned to you.
This will cause a delay in your Patient receiving medication/treatment. A separate request is needed for each medication.

NAME OF PATIENT/STUDENT		ADDRESS/ZIP		ROOM/BOOK NO	
DATE OF BIRTH	SCHOOL/ORG.#	CLUSTER	PID		
REASON MEDICATION MUST BE GIVEN IN SCHOOL:					
NAME OF MEDICATION/EQUIPMENT/TREATMENT:			DOSE:		
TIME(S) TO BE GIVEN IN SCHOOL:		TOTAL DOSAGE PER 24 HRS.:			
DATE BEGIN:			DATE END:		
INSTRUCTION FOR ADMINISTRATION/UTILIZATION:					
CONTRAINDICATIONS:					
SIDE EFFECTS:					
TREATMENT OF SIDE EFFECTS/ACTION TO BE TAKEN:					
IS ANY RESTRICTION ON ACTIVITY NECESSARY: YES <input type="checkbox"/> NO <input type="checkbox"/>					
IF YES, DESCRIBE: _____					
IS STUDENT TAKING ANY OTHER MEDICATION? YES <input type="checkbox"/> NO <input type="checkbox"/>					
IF YES, NAME OF MEDICATIONS: _____					
IS SIMILAR EQUIPMENT KEPT BY THE CHILD'S FAMILY AT HOME? YES <input type="checkbox"/> NO <input type="checkbox"/>					
PRINT NAME OF HEALTH CARE PROVIDER/CREDENTIALS			TELEPHONE		
ADDRESS			EMERGENCY NUMBER		
SIGNATURE OF HEALTH CARE PROVIDER			DATE SIGNED		

To The Principal

I authorize selected school personnel to administer the above medication, or to use the equipment or machinery as prescribed by my child's health care provider, whose signature appears on this form.

My child may self-administer medication/equipment as determined appropriate by the school nurse.

I authorize the school nurse to communicate with my child's health care provider, and my health care provider to reply, as needed regarding this medication/equipment and/or my child's response.

PARENT SIGNATURE _____ TELEPHONE NUMBER _____

DATE SIGNED _____ EMERGENCY NUMBER _____

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IN ACCORDANCE WITH CURRENT SCHOOL DISTRICT PROCEDURE, THE ADMINISTRATION OF THIS MEDICATION WAS APPROVED ON _____ DATE _____

(RETAIN IN SCHOOL)

SIGNATURE OF SCHOOL NURSE _____

TELEPHONE NUMBER OF SCHOOL NURSE _____