EAST LYCOMING SCHOOL DISTRICT
HUGHESVILLE, PENNSYLVANIA

REQUEST TO ADMINISTER MEDICATION

Name of student: ______________________________ **DOB**__________**Grade**:______

Parent/Guardian Signature:__________________________ **Date:** _______________

Your signature relieves the Board and its employees of liability for administration of medication.

The portion below is to be filled out by physician:

Name of medication: ____

Dosage (i.e. mg/units, etc.): _______________________ **Route:**_________________

Specific time to be given: __________________**Frequency:**______________________

Purpose of medication: ____

Special Instructions (if applicable):____

Allergies: ____

Length of time medication is to be given: From__________ **To**__________________
Date Date **

*****Order only valid for current school year. New order must be obtained each school year. Only Inhaler/Epi-Pens may be self-carried with a physician signed self-carry agreement. No other medications can be self-carried/administered. Please contact the nurse with questions.***

Physician Signature:________________________________ **Date:**________________

CONTROLLED SUBSTANCE RECORD
(***Completed by nurse each time parent/guardian drops off or picks up medication***)

	DATE	QUANTITY	RECEIVED FROM	RECEIVED BY
1				
2				
3				
4				
5				
6				
7				
8				
9				