

PARENTAL REQUEST FORM

FOR PRESCRIBED MEDICATION

Student Name	aka	Student ID	Date of Birth
School Name		Hours	Lunch Period

Diagnosis/Reason for Medication(s):	
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Name of Medication(s):	
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Medication Form:	<input type="checkbox"/> TABLET/CAPSULE <input type="checkbox"/> LIQUID <input type="checkbox"/> INHALER <input type="checkbox"/> INJECTION <input type="checkbox"/> OTHER:
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Special Storage Requirements:	<input type="checkbox"/> REFRIGERATE <input type="checkbox"/> NONE <input type="checkbox"/> OTHER:
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Start Date:	
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Stop Date:	<input type="checkbox"/> END OF SCHOOL YEAR <input type="checkbox"/> FOR EPISODIC/EMERGENCY EVENTS ONLY <input type="checkbox"/> OTHER/DURATION:
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Instructions: (Schedule and dosage to be given; please include all medications taken daily)	AT SCHOOL:		TIME:	
	AT HOME:		TIME:	

Restrictions/Side Effects:	
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Student Responsibility:	Is student capable and responsible for self-administering this medication? <input type="checkbox"/> NO <input type="checkbox"/> YES (SUPERVISED) <input type="checkbox"/> YES (UNSUPERVISED) May student carry this medication? <input type="checkbox"/> YES <input type="checkbox"/> NO
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Additional Information:	Please indicate if you have provided additional information: <input type="checkbox"/> YES <input type="checkbox"/> NO If so, describe:
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Date: _____ **Signature:** _____ *(Authorized Provider)*

Physician Information:	PRINTED NAME:			
	ADDRESS:			
	PHONE #:		EMERGENCY #:	

TO BE COMPLETED BY PARENT/GUARDIAN

I give permission for my child, _____, to receive the above medication at school according to the CMSD policy. It is understood that the CMSD and all of its school personnel are absolved from any responsibility, which might be associated with the administration of such medication. I understand that the medication must be brought to school in the container in which the pharmacist dispensed it. It is also understood that by requesting CMSD personnel to administer medication to my child that I also allow the prescriber to communicate with the school nurse regarding my child's treatment plan.

Date: _____ **Signature of Parent/ Guardian:** _____

Parent/Guardian Information:	PRINTED NAME:			
	ADDRESS:			
	HOME PHONE #:		WORK/EMERGENCY #:	

Reviewed by Nurse:	PRINTED NAME:		DATE REVIEWED:	
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