Code: JLCD-E

MOUNT DESERT ISLAND REGIONAL SCHOOL SYSTEM – AOS #91

Medication Administration Form

Date_____
Student's Name_____ DOB_____
Allergies_____ Physician's Name _____
Names of all medications student is currently taking_____
_____

I am requesting that my child (named above) be given the following medication at school by the school nurse or designee. I understand that all medications brought to school must be in either a prescription bottle or for over-the-counter medications, be in their original containers.
Name of medication to be dispensed:_____
Dosage to be dispensed:_____
Time to be dispensed:_____
Method of administration (i.e. by mouth, etc)_____
Reason for medication:_____

Asthma Inhalers Only

_____(Parent's initials here) The above medication is an asthma inhaler, by initialing here, I certify that my child is allowed to carry this inhaler and self-administer as prescribed.

Student Agreement

- I have demonstrated to my physician the correct use of my inhaler.
- I will never share my inhaler with another person.
- If I am not better after taking 2 puffs of my inhaler, I will see the nurse or go to the office if the nurse is not present.

Signature of student_____ Date_____

Epi-pens Only

_____(Parent's initials here) The above medication is an Epi-pen, by initialing here, I certify that my child is allowed to carry the Epi-pen and self-administer in case of emergency.

Student Agreement

- I agree never to use my Epi-pen on any other person.
- I agree to seek the help of an adult in an emergency or if I need to use, or have used my Epi-pen.

_____ _____

Signature of student Date

Insulin Only

____(Parent's initials here) The above medication is insulin, by initialing here, I certify that my child is allowed to giver her/himself insulin during the school day.

Student Agreement

- I agree never to let any other person use my insulin.
- I agree to see the school nurse or other responsible adult if I have symptoms of hypoglycemia, or if I make a mistake by giving myself too much insulin.

_____ _____

Signature of student _____ Date _____

I understand that it is my responsibility to notify the school nurse of any changes in my child's medications or allergies. I am also responsible for picking up any unused medication, either when asked to do so, or at the end of the school year.

_____ Telephone #_____/_____

Parent/Guardian Name (print) home work

_____/_____

Parent/Guardian Signature relationship

_____ Date_____Office phone_____

Physician's Signature (*needed for medications that will be given for over 14 days, and for Epi-pens, insulin and/or asthma inhalers to be carried by student*)

_____(initial here) I certify the above named student has demonstrated sufficient responsibility in self-administering the prescribed asthma inhaler, Epi-pen and/or insulin listed above and may continue to self-administer at this time.

Adopted: 01/23/17