

ALLEGHENY-CLARION VALLEY SCHOOL DISTRICT

Elementary Phone (724) 659-3555

Elementary Fax (724) 659-2963

High School Phone (724) 659-4661

High School Fax (724) 659-4774

PRIVATE PHYSICIAN REQUEST FOR ADMINISTRATION OF MEDICATION DURING SCHOOL HOURS

Dear Dr. _____,

The parent/guardian of _____ has requested that the school nurse administer medication, namely, _____ to the student during the school day.

It is our policy to request that medication be given before or after school hours whenever possible. If it is essential that the student receive medication(s) during the school hours, please complete the following information. A separate form is required for each medication. A new form is required if the medication or dose is changed and also at the beginning of each school year.

NAME OF MEDICATION: _____

DOSAGE: _____

METHOD OF ADMINISTRATION: (oral, injection, inhalation) _____

TIME SCHEDULE: (daily, PRN, etc..) _____

DURATION OF ADMINISTRATION: _____

POSSIBLE SIDE EFFECTS OR CONTRAINDICATIONS: _____

RESTRICTIONS: (sports, gym class, etc..) _____

OTHER MEDICATIONS PRESCRIBED BY PHYSICIAN THAT STUDENT IS TAKING OUTSIDE OF SCHOOL HOURS: _____

IS STUDENT CAPABLE OF SELF-ADMINISTRATION: YES NO

DIAGNOSIS FOR WHICH MEDICATION IS BEING GIVEN: _____

DATE: _____ PHYSICIAN'S SIGNATURE: _____

PHYSICIAN'S PHONE : _____

