FREMONT COUNTY SCHOOL DISTRICT NO. 2

Every Day Counts: Educate, Engage, Empower

FCSD #2 Request For Administration of Medication

Parent/Guardian to complete:

Student Name: _____ Date of Birth: _____

Grade: _____ Allergies: _____

Medical Provider to complete:

Medication: _____

Diagnosis: _____

Time to be given: _____ Frequency: _____ Route: _____ Dose: _____

If PRN, for what symptoms: _____

If PRN, frequency: _____

Relevant Side effects: (please describe):

_____

Please check one of the following:
Discontinue: ☐ End of school year ☐ Other (specify): _____

Prescriber's Signature: _____Date: _____

Prescriber'sName/Title:_____Date:_____

◆◆ **For Self – Administration ONLY** ◆◆

TO BE COMPLETED **FOR INHALER OR EPI-PEN** ONLY

Fremont County School District permits a student to possess and self administer asthma or anaphylaxis medication at school and at school related functions. Completion of the following information **by the authorized prescriber** acknowledges that this student has been instructed and has the skills and knowledge on self-administration of this medication.

This student may carry this medication: ☐ Yes ☐ No

Prescriber's Signature: _____Date: _____

I give permission for (name of child) _____to receive the above-stated medication at school according to FCSD #2 school policy. I release FCSD #2 and their employees from any claim or liability for administering prescribed medication to this student. I HAVE READ THE MEDICATION GUIDELINES AND ASSUME THE RESPONSIBILITIES AS STATED ON THIS FORM. I authorize the school nurse to communicate with the health care provider as allowed by HIPPA.
Signature: _____ Date: _____ Relationship:_____

Phone: _____

Order Reviewed by the school Nurse: _____ Date: _____