

THE SCHOOL DISTRICT OF PHILADELPHIA
SCHOOL HEALTH SERVICES

REQUEST FOR ADMINISTRATION OF MEDICATION, TREATMENTS OR USE OF EQUIPMENT IN SCHOOL

(PLEASE SEE MESSAGE TO PHYSICIAN AND PARENT ON BACK OF FORM)
PHYSICIAN, PLEASE NOTE: Fill in all of the spaces. Missing information will cause the form to be returned to you. This will cause a delay in your patient receiving medication / treatment. A separate request is needed for each medication.

NAME OF PATIENT/STUDENT		ADDRESS/ZIP		ROOM/BOOK NO.
DATE OF BIRTH	SCHOOL/ORG.#	REGIONAL OFFICE	PID	
DIAGNOSIS:				
REASON MEDICATION MUST BE GIVEN IN SCHOOL:				
NAME OF MEDICATION/EQUIPMENT/TREATMENT:			DOSE:	
TIME(S) TO BE GIVEN IN SCHOOL:		TOTAL DOSAGE PER 24 HRS:		
DATE BEGIN:		DATE END:		
INSTRUCTION FOR ADMINISTRATION/UTILIZATION:				
CONTRAINDICATIONS:				
SIDE EFFECTS:				
TREATMENT OF SIDE EFFECTS/ACTION TO BE TAKEN:				
IS ANY RESTRICTION ON ACTIVITY NECESSARY: YES <input type="checkbox"/> NO <input type="checkbox"/>				
IF YES, DESCRIBE:				
IS STUDENT TAKING ANY OTHER MEDICATION? YES <input type="checkbox"/> NO <input type="checkbox"/>				
IF YES, NAME OF MEDICATIONS:				
IS SIMILAR EQUIPMENT KEPT BY THE CHILD'S FAMILY AT HOME? YES <input type="checkbox"/> NO <input type="checkbox"/>				
PRINT NAME OF HEALTH CARE PROVIDER/CREDENTIALS			TELEPHONE	
ADDRESS			EMERGENCY NUMBER	
SIGNATURE OF HEALTH CARE PROVIDER			DATE SIGNED	

To The Principal

- I authorize selected school personnel to administer the indicated medication, or to use the equipment or machinery as prescribed by my child's health care provider, whose signature appears on this form.
- Medication is to be administered by the Certified School Nurse. In the absence of the Certified School Nurse, it may be administered by the Principal or his/her designees. Certified School Nurse will provide instruction for administration of medication or use of equipment to the Principal or his/her designees.
- My child may self-administer medication/equipment as determined appropriate by the school nurse.
- I authorize the school nurse to communicate with my child's health care provider and my health care provider to reply, as needed, regarding this medication/ equipment and/or my child's response.

PARENT SIGNATURE _____ TELEPHONE NUMBER _____

DATE SIGNED _____ EMERGENCY NUMBER _____

IN ACCORDANCE WITH CURRENT SCHOOL DISTRICT PROCEDURE

- I have assessed this student and he/she has demonstrated competency and may self administer this medication/treatment () yes () no
- The administration of this medication/treatment was approved on: _____ DATE

SIGNATURE OF SCHOOL NURSE _____

TELEPHONE NUMBER OF SCHOOL NURSE _____