**NORTHGATE SCHOOL DISTRICT**
**Request for Medication Administration in School**

**To be completed by licensed prescriber:** **DATE: _____**

| **Student's Name** | **Student ID#** | **Grade/Homeroom** |
|---|---|---|
| | | |

| **Medication** | #1 | #2 |
|---|---|---|
| **Dosage** | | |
| **Time of Administration** | | |
| **Length of Administration** | Start Stop | Start Stop |
| **Reason for Medication** | | |
| **Administration Instructions** | | |
| **Side Effects** | | |
| **Competency for Self Administration** | I, _____, certify that this student has a potentially life threatening illness (licensed prescriber's printed name) and requires an inhaler or auto injecting epinephrine. This student is competent and has been instructed in the proper method of self administration of said medication. This student may therefore carry and self administer his/her inhaler or auto injecting epinephrine. | |
| **Signature of Licensed Prescriber** | Name _____ Phone _____ (not valid without licensed prescriber signature) | |

**To be completed by Parent/Guardian:**

I give permission for my child to receive the above noted medication at school according to School Board Policy. I waive and release the District and any District employee from any and all liability or responsibility for the administration of the medication or benefits or consequences of the medication and acknowledge that the District bears no responsibility for ensuring that the medication is taken. I also give permission for the certified school nurse to contact the licensed prescriber, as necessary, regarding the medication.

**Parent/Guardian Signature:** _____
(not valid without signature)

TELEPHONE

Home: _____ Work: _____
Cell: _____

**MEDICATIONS CAN ONLY BE ADMINISTERED BY LICENSED MEDICAL PERSONNEL**