MEDICATION REQUEST (Prescription & Over the Counter)
SELF-ADMINISTER MEDICATION (ASTHMA)
School Year 2018-2019 (Renew each year)

For all over the counter medicines, a doctor signature is not needed, but this form is!! All medicines must be brought to the District Secretary's office. Your child's name will be put on the bottle, so there will be no mix-up. Asthma medication may be carried on the person & administered, but this medication form must be completed by doctor and parent/guardian & be kept on file at the office. By signing this form you agree that the student may self-administer his/her asthma medicine (only) on his/her own without school personnel supervision.

NAME OF STUDENT____

Date of Birth_______/______/________ Sex: (Please circle) Female Male

MEDICATION____

DOSAGE:_______________________________________TIME:__________________________

Beginning Date_______________________________ Ending Date___________________________

Possible Side Effects____

I request that Joliet Public Schools (office personnel) allow my child to take the medication as directed above. I authorize the release & exchange of health information from the above health care provider to the Carbon County School Nurse & the school. A health care provider's signature will be required for all prescription medication use. The School District, Carbon County School Nurse, or the school office will not be held liable in anyway due to the administration of medication described above.

PARENT/GUARDIAN NOTE: It is the responsibility of the parent/guardian to furnish the medication. Medication must be in the original prescription bottle with a pharmacy label including child's name, name of medication, dosage, time to be taken, duration of time to be taken, & the physician's name. Non-prescription medications must be in the original bottle/container. Any changes to the medication will require new consent forms to be completed. To avoid adverse medication reactions at school, the first dose of medication must be administered at home. Any unused medication not picked up at the end of the school year will be disposed of.

Signature of Parent/Guardian: ____

Date______________________________ Emergency Phone #________________________________

Name/Signature of Health Care Provider____

Phone#___________________________________ FAX#____________________________________