LEVITTOWN PUBLIC SCHOOLS
DEPARTMENT OF HEALTH SERVICES
REQUEST FOR ADMINISTRATION OF MEDICATION
DURING SCHOOL DAY

STUDENT'S NAME: _____ DOB_____
HOME ADDRESS:_____ Zip Code:_____
TELE.#:_____ Grade_____

Dear Parent/Guardian,
Whenever possible, medication should be given at home to avoid disruptions to the school day. If your physician requires medication to be administered at school, please submit this completed form before sending medication. A new form is needed for each medication change and must be renewed annually. State law allows medication at school only with written instructions from both the physician and parent. Students may not take medication without official written authorization or supervision.

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1. TO BE COMPLETED BY PARENT OR GUARDIAN
I request the school to administer the medication as described below by my physician to my child. I will supply the school nurse with the medication prescribed below in the original container, or a duplicate, professionally labeled by the pharmacist for this purpose.
DATE:_____ SIGNATURE:_____
RELATIONSHIP TO STUDENT:_____

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2. TO BE COMPLETED AND SIGNED BY PHYSICIAN:
DIAGNOSIS_____
Medication Name:_____
Dose:_____
Route:_____
Time/Frequency_____ If PRN, Frequency_____
Duration of Administration:_____
Possible Side Effects:_____
Conditions under which medication should not be given, if any_____

STUDENT SKILL LEVEL:
☐Nurse Dependent Student: *Nurse must administer medication.*
☐Supervised Student: *Student self-administers, under adult supervision.*
☐Independent Student: ***Student is self-carry/self-administer only for anaphylaxis medications, diabetes, pancreatic enzymes or rescue inhalers***

☐I attest student demonstrated ability to self-administer the prescribed medication effectively during school, field trips, and school sponsored events. _____*Physician's initials*

SIGNATURE OF PHYSICIAN_____
PHYSICIAN'S STAMP_____ DATE_____

Parent/Guardian Permission for Independent Use and Carry
I agree that my child can use their medication effectively and may carry and use this medication independently at any school/school sponsored activity. Staff intervention and support is needed only during an emergency. I will advise my child to notify the school nurse anytime they self-administer at school.
Parent/Guardian Signature: _____ Date: _____

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