



Health Services

Physician's and Parent's Request for the Administration of Medication
During School Hours by School Personnel

Name of Student: _____ Birthdate: _____ Grade: _____ Date: _____

PHYSICIAN SECTION

Physical condition for which the medication is given. If it is for an allergic condition, please specify what type of reaction and indicate in detail visible symptoms which would indicate the necessity of administering the medication i.e. localized swelling, generalized swelling, hives, breathing problems.

Medication: _____ Dosage and method of administration: _____

Possible reactions that need to be reported to parent or physician: _____

Student may carry asthma medication and is capable of using it independently. ☐ Yes ☐ No

After medication does student need to rest in health office, go home, go to the hospital or doctor's office, other _____

Medication to continue until (date) _____

The above medication cannot be scheduled for other than during school hours and trained non-medical personnel can administer such medication.

Physician signature: _____ Physician name printed: _____

Address _____ Phone: _____

PARENT/GUARDIAN SECTION

I give permission for my child to receive the medication described above. School personnel will call 911 in the event an emergency occurs and parent cannot be reached. The following emergency numbers are for people who know about my child's condition and can be called if my child needs help.

Parent signature: _____ Phone number _____ Date: _____

Print name: _____ Emergency phone numbers: _____

All medication must be received at school:

1. In its original pharmacy container with correct dosage
2. Labeled with student's name
3. Brought to school by parent or responsible adult

Principal signature: _____ Date: _____

Health Staff signature _____ Teacher signature _____

Medical Statement to Request Special Meals and/or Accommodations

This statement must be completed in its entirety and submitted to the school before any meal substitutions can be made for children with disabilities. The parent/guardian should review this form annually and initial and date if no changes are needed. Any changes require the submission of a new form signed by the child's physician.

(1) Name of Participant	(2) Age or DOB	(3) Sponsor	(4) Site
(5) Name of Parent, Guardian, or Auth. Rep.	(6) Telephone (Parent, Guardian, or Auth. Rep.) ()	(7) Site Telephone Number ()	
(8) Must check one: <input type="checkbox"/> Participant is disabled or has a medical condition and <i>requires</i> a special meal or accommodation. Sponsors must comply with requests for special meals and any adaptive equipment. A licensed physician must sign this form. <input type="checkbox"/> Participant is not disabled, but is <i>requesting</i> a special meal or accommodation. An example may include a food intolerance. However, food preferences are not included as an example. Sponsors are encouraged to accommodate reasonable requests. A licensed physician, physician's assistant, registered dietitian or registered nurse must sign this form.			

(9) Disability or medical condition requiring a special meal or accommodation: _____

(10) If participant is disabled, provide a brief description of participant's major life activity affected by disability: _____

(11) Diet prescription and/or accommodation: (Please describe in detail to ensure proper implementation.) _____

(12) Indicate texture: ☐ Regular ☐ Chopped ☐ Ground ☐ Pureed

Foods to be omitted and substitutions: Please list specific foods to be omitted and suggest substitutions. You may use the back of this form or attach a sheet with additional information.

(13) Foods to be omitted

(14) Suggested substitutions

(15) Adaptive Equipment: _____

(16) Signature of Preparer*	(17) Printed Name	(18) Telephone ()	(19) Date
(20) Signature of Medical Authority*	(21) Printed Name	(22) Telephone ()	(23) Date
(24) Signature of Parent/Guardian	(25) Printed Name	(26) Telephone ()	(27) Date

*Physician's signature is required for participants with a disability. For non-disabled participants, a licensed physician, physician's assistant, or registered nurse must sign the form.

The information on this form should be updated to reflect the current medical and/or nutritional needs of the participant.

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