Seneca Valley School District

Private Physician Request for Administration of Medication during School Hours
School Year __________

Name of Student ________________________________ **Grade**_____ **Homeroom**______

Medication	Dosage	Time	Duration (current school year or lesser period as stated)	Reason

1. ____

2. ____

3. ____

____
Printed Physician Name or Stamp

____
Physician Signature Date

____
Phone Number

Physician to complete this section for Inhalers and EpiPens only:

_____ This student is capable of self-administration of inhaled asthma medications and/or EpiPen.*
Initials

_____ This student should be allowed to carry inhaler and/or EpiPen with him/her at school.*
Initials

Curtailment of Specific School Activities: No____Yes____ (please explain)

****Please Note: For the safety of all our students, any student who carries or self-administers medication must have a care plan to address his/her specific needs - to be developed with the school nurse.***

PARENT/STUDENT SECTION

I authorize the above medication(s) to be administered to my child:

- I request that the school comply with the physician's order for medications and I relieve the school of any responsibility for the benefits or consequences of the medication.
- I acknowledge that the school bears no responsibility for ensuring that the medication is taken and that the school nurse may need to verify my child's capability to self-administer medication by means of a student interview and/or observation of my child's technique. ****This only applies to emergency or rescue medications (Inhalers and EpiPens). All other medications must be kept in the health office at all times.*

____
Student Signature Date

____
Parent/Guardian Signature Date

____
School Nurse Date Received

4/10