ROMEO COMMUNITY SCHOOLS

REQUEST FOR SELF-POSSESSION/SELF ADMINISTRATION OF MEDICATION

Amanda Moore Elementary School Telephone: 586-752-0260 Fax: 586-752-0468

PARENT

Under certain conditions, as a service to you and for the welfare of your child, school personnel may agree to honor parent requests for the administration of necessary medication to students.

PLEASE BE SURE THE FOLLOWING STEPS HAVE BEEN TAKEN:

*Medication(s) must be in original container and clearly labeled.

*Medication must be brought to school by an adult

*Prescription medication must indicate: (1) student's name (b) dosage (c)doctor's name , (d) pharmacy name (e) date issued (f) prescription number

The written statement below, signed and dated by the attending physician, supporting this parental request is required. The physician's statement must provide clear directions for administering the medication in school.

I do hereby request that my (son/daughter) be allowed to possess and self-administer the medication recommended below by the physician, and I give permission for school staff to contact my child's doctor regarding administration and effects of the medication ordered:

Student Name: _____ ***School:*** _____

Address: _____

(Street Name) (City) (State) (Zip)

Grade: _____ ***Home Phone:*** _____ ***Cell Phone:*** _____

Parent/Guardian Signature: _____ ***Date:*** _____

PLEASE NOTE THAT SCHOOL STAFF ARE ADMINISTERING MEDICATIONS.
ALL LANGUAGE/DIRECTIONS MUST BE IN LAY TERMS.

PHYSICIAN

I recommend that _____carry on their person and self-administer the medication listed below. This student understands when and how to use the medication and to notify an adult school staff if medication is not effective. For inhaled medication we recommend an extra inhaler be left in the school office.

*Medication Name: _____

*Total Dosage: _____mg., _____ puffs, _____ other: _____

*Times to Administer: _____Lunch _____Other time _____As Needed (Specify symptoms or circumstances when medication is to be given.): _____

*Frequency: _____

*Purpose of medication: _____

*Possible side effects: _____

Physician's Signature: _____ **Date:** _____

Physician's Name: _____

Address: _____ **City:** _____ **State:** _____ **Zip:** _____

Telephone: ( ) _____ Fax: ( ) _____