HEALTHY CPS
— OFFICE OF STUDENT HEALTH & WELLNESS —

PROVIDER'S REQUEST FOR ADMINISTRATION OF MEDICATION TO A STUDENT

(Note: One form needed for EACH medication to be administered)

Name of Student _____ Date of Birth _____ ID Number _____

Address _____ Parent/Guardian Telephone Number _____

Name of Medication _____ Type of Medication (tablet, liquid, inhaler, etc) _____

Dosage _____ Route _____ Time _____ Condition for which Medication is Ordered _____

Possible Side Effects _____

Provider (MD, DO, NP, PA) Name (print) _____ **Provider Signature** _____

Hospital/Clinic Affiliation _____ **Address** _____ **Telephone Num.** _____ **Fax Num.** _____

Date _____

*This order is valid for 1 year from date of signature ****Any change in medication or dose requires a new order form**

Parent/Guardian Name (print) _____ Parent/Guardian Signature _____ (Signature implies agreement to student receiving above named medication ordered by the above named provider during school hours)

PERMISSION FOR SELF-ADMINISTRATION OF MEDICATION

(Do NOT complete this section unless requesting for self-administration of the ordered medication)

☐ I am requesting that the above-named student **be allowed** to self-administer the above-named medication during school hours.

Provider (MD, DO, NP, PA) Name (print) _____ Provider Signature _____

Parent/Guardian Name _____ Signature _____

(Signature implies agreement to student self-administering above-named medication ordered by the above-named provider during school hours)