Re-Education Services, Inc. Providing Special Education & Individualized Programming

ADMINISTRATION OF MEDICATION REQUEST

ONE MEDICATION PER FORM

STUDENT NAME: _____ **DATE OF BIRTH:** _____

PHYSICIAN AUTHORIZATION *(Information should be written in lay language with no abbreviations)*

Name of Medication *(trade name and/or generic)*	Dosage *(must be exact, will not accept 1 to 2 tablets, 2 to 4 puffs, etc.)*	
Time *(please give exact time, will not accept morning, lunchtime, etc.)*	Duration of Administration ☐ _____ School Year **or** ☐ From _____ To _____	
Diagnosis/Reason for Medication		
Additional Special Instructions		
Precautions, Reactions, or Side Effects		
Procedures for School Employees (if the medication does not produce the expected relief)		
Epinephrine Auto-Injector Only – The above named student is authorized to: (valid for students age 12 and older) ☐ Keep emergency medication in his/her possession as permitted by law (this includes school transportation) ☐ Self-Administer the prescribed medication as trained by physician		
Asthma Inhaler Only – The above named student is authorized to: (valid for students age 12 and older) ☐ Keep emergency medication in his/her possession as permitted by law (this includes school transportation) ☐ Self-Administer the prescribed medication as trained by physician		
Physician Signature	Date	
Physician Name	Phone	Fax

PARENT/GUARDIAN AUTHORIZATION

☑ I authorize Re-Education Services to administer the above medication as directed by the physician authorization. ☑ I authorize Re-Education Services to talk with the prescriber or pharmacist to clarify medication order. ☑ I agree to release, indemnify, and hold harmless Re-Education Services, and any of their officers, staff members, or agents from lawsuit, claim, demand, or action against them for administering prescribed medication to this student, provided Re-Education Services staff are following the physician's authorization. ☑ I understand that the medication must be in the **original** container and be properly labeled with the student's name, prescriber's name, date of prescription, name if medication, dosage, strength, time interval, route of administration and date of drug expiration when appropriate.		
Parent/Guardian Signature	Date	Phone

PARENT/GUARDIAN SELF-CARRY AUTHORIZATION

☐ Epinephrine Auto-Injector: I authorize my child to carry and self-administer an epinephrine auto-injector, as prescribed by the physician authorization. ☐ Asthma Inhaler: I authorize my child to carry and self-administer an asthma inhaler, as prescribed by the physician authorization.		
Parent/Guardian Signature	Date	Phone

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