

**EAST LYCOMING SCHOOL DISTRICT
HUGHESVILLE, PENNSYLVANIA
REQUEST TO ADMINISTER MEDICATION**

Name of student: _____ DOB _____ Grade: _____

Parent/Guardian Signature: _____ Date: _____

Your signature relieves the Board and its employees of liability for administration of medication.

The portion below is to be filled out by physician:

Name of medication: _____

Dosage (i.e. mg/units, etc.): _____ Route: _____

Specific Time to be given: _____ Frequency: _____

Purpose of medication: _____

Special Instructions (if applicable): _____

Allergies: _____

Length of time medication is to be given: From _____ To _____

Date Date

*****Order only valid for current school year. New order must be obtained each school year. Only Inhaler/Epi-Pens may be self-carried with a physician signed self-carry agreement. No other medications can be self-carried/administered. Please contact the nurse with questions.***

Physician Name (Print): _____ Date: _____

Physician Signature: _____ Date: _____

CONTROLLED SUBSTANCE RECORD

(Completed each time parent/guardian drops off or picks up medication)

	DATE	QUANTITY	RECEIVED FROM	RECEIVED BY
1				
2				
3				
4				
5				
6				
7				
8				
9				