BREWER SCHOOL DEPARTMENT
REQUEST/PERMISSION TO ADMINISTER MEDICATION IN SCHOOL

Student's Name:_____ DOB: _____
School: _____ Grade:_____ Teacher: _____

To be completed by Health Care Provider:

Name of medication:_____
Reason for medication:_____
Route:
☐ Tablet/capsule ☐ Liquid ☐ Inhaler ☐ Injection ☐ Nebulizer ☐ Other_____
Dosage (amount):_____
Time to be given:_____
Restrictions and/or important side effects: ☐ None anticipated
☐ Yes. Please describe in detail:_____
_____
_____
_____
Date prescribed:_____
Date to be discontinued:_____
Any other necessary instructions or information: _____

IF APPLICABLE:
This student is both capable and responsible for self-administering this medication if allowed by School Committee policy.
☐ No ☐ Yes - supervised ☐ Yes - unsupervised
This student may carry this medication if allowed by Board policy: ☐ No ☐ Yes

NOTE: THE SCHOOL NURSE MAY CONTACT YOU IF THERE ARE FURTHER QUESTIONS CONCERNING THIS MEDICATION REQUEST.

Health Care Provider's Signature:_____Date:_____
Printed Name: _____
Address:_____
Phone Number:_____ FAX Number: _____

Note: Any changes to the information above shall require a new request/permission form.

School Nurse Contact Information

9-12	Prek-8`
Brewer High School	Brewer Community School
Fax: 989-8652	Fax: 404-5730
Phone: 989-3760	Phone: 404-5702

Please Print

Student's Name_____
Name of Medication _____

To be completed by Parent/Guardian:

I request and give permission for Brewer School Department nurses and other trained, unlicensed personnel to administer the above named medication to (student's name) _____ _____ in accordance with Brewer School Committee Policy JLCD – Administering Medications to Students.

OR:

I request and give permission for (student's name) _____ to self-administer the above-named medication in accordance with Brewer School Committee Policy JLCD – Administering Medications to Students.

I understand and agree that if the school nurse has questions regarding the health care provider's order, that the nurse may contact the child's health care provider and obtain additional information from him or her about the medication, and I consent to the health care provider providing that information.

Signature:_____ Relationship:_____
Date: _____

To be completed by School:
Date received: _____ By whom:_____
Date reviewed:_____ Reviewed by:_____
Notes:

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