



# UINTAH SCHOOL DISTRICT

635 West 200 South  
Vernal, UT 84078  
(435) 781-3100

## REQUEST FOR ADMINISTRATION OF MEDICATION IN SCHOOLS

Name of Student: \_\_\_\_\_ Date of Birth: \_\_\_\_\_

Address: \_\_\_\_\_ Home Phone: \_\_\_\_\_

School: \_\_\_\_\_ Business Phone: \_\_\_\_\_

### - PARENT'S REQUEST AND AUTHORIZATION -

I, the undersigned, request and authorize the School Health Nurse or alternate School Personnel to administer medication as prescribed by the student's physician.

I request and authorize the release of information between the school, the School Health Nurse and the prescribing physician pertinent to the student's condition.

I understand that a new request is to be processed should there be a change in medication or physician's orders.

\_\_\_\_\_  
Signature of Parent or Legal Guardian

\_\_\_\_\_  
Date

### - TO BE COMPLETED BY PHYSICIAN -

1. Name of Medication \_\_\_\_\_
2. Specific time(s) and dose(s) to be given at school \_\_\_\_\_
3. Will student be on medication entire school year? \_\_\_\_\_ Yes \_\_\_\_\_ No  
If no, how long? \_\_\_\_\_
4. Common side effects can include: \_\_\_\_\_
5. Are there any restrictions? \_\_\_\_\_ Yes \_\_\_\_\_ No  
If yes, what and how long? \_\_\_\_\_
6. If medication is an inhaler, should student carry at all times? \_\_\_\_\_ Yes \_\_\_\_\_ No

\_\_\_\_\_  
Printed Name of Physician

\_\_\_\_\_  
Signature of Physician

\_\_\_\_\_  
Date