WESTERN WAYNE SCHOOL DISTRICT

Request for Administration of Medication During School Hours

EverGreen Elementary	**R.D. Wilson Elementary**	**WW Middle School**	**WW High School**
Ph: 1-800-321-9973	Ph: 1-800-321-9973	Ph: 1-800-321-9973	Ph: 1-800-321-9973
Fax: 570-341-1220	Fax: 570-341-1224	Fax: 570-341-1223	Fax: 570-341-1222
C. Davis, CSN	M. Shelp, CSN	Lori Krol, CSN	D. Johnson, CSN

Dear Health Care Provider,

It is the policy of Western Wayne to request that medication be given at home whenever possible. However, if it is essential that the student receive medication at school, please provide the following information. Also, please note where indicated below if the student may *independently self-administer* rescue inhalers or Epi-Pens.

Physician's Permission

Date_____

I want _____ to receive the following medication(s) during school hours:

	Medication #1	Medication#2	Medication #3
Name of Medication			
Dosage			
Route of Administration			
Time to be Given			
Duration of Order			

Condition/Diagnosis_____

Yes **No** Is the student capable of ***supervised self-administration***?

Yes **No** Has the student demonstrated the capability for ***independent self-administration*** and responsible behavior regarding the use of a rescue inhaler of Epi-Pen?
(The student must notify the school nurse following independent use of the medication, but the school bears no responsibility for ensuring that the medication is taken as ordered.)

PHYSICIAN'S SIGNATURE_____ ***PHONE***_____
FAX_____

Parent/Guardian Permission

Permission is given for my child to receive the medication(s) as ordered above during school hours. I do hereby release, discharge and hold harmless the Western Wayne School District, its agents and employees, from any and all liability and claims whatsoever for the administration of the above medication(s) to my child.

Parent/Guardian's Signature_____Date_____