# ADMINISTERING MEDICATION/PERSONAL CARE TO STUDENTS APPROVAL FORM

| The following information will be used for the purpose of responding to the medical needs of your child. | |
|---|---|
| Student Name: | D.O.B. MM/DD/YYYY |

| | |
|---|---|
| Parent Name: | Phone Number:<br>Business Number: |
| Parent Name: | Phone Number:<br>Business Number: |
| Emergency Contact: | Phone Number: |
| Emergency Contact: | Phone Number: |
| Doctor/Clinic: | Phone Number: |

**1. Medical intervention, which is being requested of the school staff:**

☐ Medication Administration

☐ Medical Treatment/Personal care (Please describe)

**2. Purpose of Medication/Medical Treatment/Personal care:**

**3. Student is able to self-administer medication/medical treatment:** ☐ Yes ☐ No

If yes, please indicate if and how the student is to carry/access medication (e.g., inhaler, EpiPen):

If no, please provide specific instructions:

| **4. Allergic reactions and precautions to be taken:** |
| --- |
| **5. Actions parent requests to be taken by school in the event of illness or injury:** |

**The information and procedures indicated above remain in full force until revoked or revised in writing. It shall be the responsibility of the parent to advise the school of any changes in the student's health during the school term.**

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Parent Signature Date