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Medical providers may FAX form to: Middle School- 610-562-1425

**HAMBURG AREA SCHOOL DISTRICT**

**Parent/Guardian’s Request to Administer Medication in School/Field Trip**

Dear Parent/Guardian,

To request medication administration at school, please note:

* This form must be completed and signed by you and your child’s medical provider.
* A new form is needed for all changes in medication, dose, or time.
* The medication should be brought to school by a parent/guardian or responsible adult.
* The medication container must be labeled by the pharmacy with the student’s name, prescriber name, name of medication, dosage, route, conditions for storage, prescription date, and expiration date.
* Expired and discontinued medication not picked up by the last day of school will be destroyed.

**Health Care Provider’s Instructions for Administering Medication in School**

|  |  |  |  |  |  |  |  |  |
| --- | --- | --- | --- | --- | --- | --- | --- | --- |
| **Name of Student** | | | | **Birthdate** | | | | |
|  | | | |  | | | | |
| **Diagnosis** | | | | | | | | |
|  | | | | | | | | |
| **Medication** | **Dose** | | **Route** | | **Time** | | **Frequency** | |
|  |  | |  | |  | |  | |
|  | Check if student can self-carry medication (**Only for** **inhaler/EpiPens**) | |
| **Physician/Prescriber Name/ Address (City, State, Zip)**  (Please Print) | | **Phone Number** | | | | **Signature of Physician/Prescriber** | | |
|  | |  | | | |  | | |
| **Fax Number** | | | | **Date** | | |
|  | | | |  | | |

**To Be Completed by Parent/Guardian**

|  |  |  |  |
| --- | --- | --- | --- |
| **School that Child Attends** | **Grade** | **Home Phone** | **Work/Emergency Phone** |
|  |  |  |  |
| **Signature of Parent/Guardian** | | **Date** | |
|  | |  | |