**ALL SAINTS EPISCOPAL SCHOOL**
**MEDICATION ADMINISTRATION REQUEST**
**FOR DAILY ADMINISTRATION LASTING GREATER THAN TWO WEEKS**

- Parents/guardians must provide medication. No more than a 30 day supply of medication will be accepted.
- All medication must be in the original container, clearly labeled with the student's name, the dosage and directions for administration.
- The Medication Administration Request must be completed each school year AND when there is any change to the original request including a medication and/or dose change. A separate form must be completed for each medication.
- Parents/guardians are strongly encouraged to pick up all medication immediately after it is discontinued. **At the end of the school year, all medication that has not been picked up will be destroyed.**

**Student Name** _____ **Grade** _____ **Age** _____ **Weight** _____ **Date** _____

Teacher _____ Physician's Name _____ Phone _____

List any medication allergies _____

List all medication(s) student is currently taking: _____

I hereby request and authorize my child to receive the medication listed below:

**Medication** _____ **Dose** _____

**Time to be administered** _____ **Date(s) to be administered** _____
(maximum limit of one school year)

**Condition for which medication is required** _____

- **I authorize my child to transport this medication to and/or from school.**
  (Please circle one) **YES** **NO**

- **Student may take morning dose of medication at school, if forgotten at home, with parent permission by phone.**
  (Please circle one) **YES** **NO**

**Plan for Field Trips or Off-Campus Events:**
I understand that **it is the responsibility of the Parent/Guardian to notify the school nurse of the date and time of a field trip/Off-Campus Event**, if medication is to be administered while the student is attending the Field Trip/ Off-Campus Event (preferably at least one day in advance). I understand a trained staff member, designated by the Headmaster, may be responsible for administering medication to my child while attending a field trip/Off-Campus Event.
_____(Initials of parent/guardian)

My signature below indicates that I request that ASES staff administer the medication specified above to my child, and I am giving my permission for the school nurse or headmaster to contact the physician for additional information, if needed.

Parent/Guardian Name _____ Signature _____

Phone (Home) _____ (Work) _____ (Cell) _____