PENTA CAREER CENTER
9301 Buck Road • Perrysburg, OH 43551 • P 419.666.1120 • F 419.666.6049

Request to Administer Medications

Student Name: _____ Date of Birth: _____

Address: _____
Street **City** **Zip**

Grade: _____ Career Program_____ Member School: _____

As parent/guardian, I/we give the Penta Career Center School Nurse permission to contact the prescribing health care provider for clarification of orders and to discuss situations pertaining to prescribed medications taken during the school day. _____
Parent/Guardian Initials

Name of Drug/ mg: _____ Dosage: _____
Administration Time: _____ Date to Begin: _____through _____/end of school year
(circle)
Adverse reactions to be reported to physician: _____
Special Instructions: _____

Name of Drug/ mg: _____ Dosage: _____
Administration Time: _____ Date to Begin: _____through _____/end of school year
(circle)
Adverse reactions to be reported to physician: _____
Special Instructions: _____

Authorization to self-carry and administer Asthma inhaler and/or Epinephrine pen: _____/_____
Parent Physician/HCP

_____ _____ _____ _____
**** Parent/ Guardian Signature** **Date** **Physician/ HCP Signature** **Date**

Physician/HCP Name (printed): _____ Phone: _____
Fax: _____
Address:
_____
Street City/ State/ Zip

***Note: The parent/guardian must agree to (1) Deliver the medication to school (2) Notify the school if a change in prescription dosage, time, procedure or discontinuation is made along with the physician/ HCP signed statement of changes. (4) Pick up any medication which is considered a controlled substance (ADHD medications/ Narcotics) when it is discontinued at the end of the school year.**

PENTA CAREER CENTER
9301 Buck Road • Perrysburg, OH 43551 • P 419.666.1120 • F 419.666.6049

Request to Administer Medications

Student Name: _____ Date of Birth: _____

Name of Drug/ mg: _____ Dosage: _____
Administration Time: _____ Date to Begin: _____through _____/end of school year
(circle)
Adverse reactions to be reported to physician: _____
Special Instructions: _____

Name of Drug/ mg: _____ Dosage: _____
Administration Time: _____ Date to Begin: _____through _____/end of school year
(circle)
Adverse reactions to be reported to physician: _____
Special Instructions: _____

Name of Drug/ mg: _____ Dosage: _____
Administration Time: _____ Date to Begin: _____through _____/end of school year
(circle)
Adverse reactions to be reported to physician: _____
Special Instructions: _____

Physician/ HCP Initials: _____ Date: _____
**(Necessary only if prescribed medications listed on this page)

***Note:** The parent/guardian must agree to (1) Deliver the medication to school (2) Notify the school if a change in prescription dosage, time, procedure or discontinuation is made along with the physician/ HCP signed statement of changes. (4) Pick up any medication which is considered a controlled substance (ADHD medications/ Narcotics) when it is discontinued at the end of the school year.