MEDICATION REQUEST / PROCEDURE FORM 2025-2026

Portage Community School District

Medications are to be administered at home whenever possible. All appropriate portions of this form must be completed before medication and/or a procedure can be administered at school. **One form for EACH medication or procedure is required.** Approved 9.2011, rev. 1.2025

To Be Completed by Parent

STUDENT: _____ BIRTHDATE: ____/____/____ GRADE: _____ WEIGHT: _____ pounds

PHONE: _____/_____/_____ Healthcare Provider Name and Phone Number: _____

MEDICATION / PROCEDURE:

Name of one Medication or Procedure needed: _____

Diagnosis or reason: _____ Expiration Date on Package _____

Scheduled Time to be given at school: _____ Or As Needed and When may it be repeated: _____

Dates to be Given at school (**required**): Start date: _____ (mm/dd/yyyy) End date: _____ (mm/dd/yyyy)

Dose at School: _____ Route: Mouth _____ Injected _____ Inhaled _____ Other Route _____

Directions on package label: _____

Precautions/side effects of concern: _____

PARENT/GUARDIAN CONSENT: Review each item before signing.

- **I understand that all medication should be delivered to the school and picked up from the school by parent/guardian/responsible adult unless the physician indicates below self carry, self administer.**
- I request and authorize that school personnel administer this medication or procedure at school.
- I will supply medication in its original, currently dated, properly labeled container. (Request extra bottle from Pharmacist).
- I will obtain a new healthcare provider's order and notify the school in writing of any changes.
- I authorize school personnel to exchange information verbally or in writing with my child's physician regarding this medication or the conditions for which it is prescribed. This information will be kept for 7 years beyond the child's enrollment end date.
- A photo may be taken at school to identify this student and attached to this form.
- A weight check may be completed to verify appropriateness of dose.
- I understand that trained, non-medical school personnel will administer medication/procedure.
- I agree to hold the School District, its employees and agents who are acting within the scope of their duties harmless in any and all claims arising from the administration of this medication at school.
- For any age student-ASTHMA INHALERS and EPI PENS ONLY: This student is capable of self-administration and may carry inhaler or EPI PEN and self-administer at school. **YES ☐ NO ☐ (REQUIRES practitioner signature and agreement too.)**
- PORTAGE **HIGH SCHOOL STUDENT** NON-CONTROLLED SUBSTANCES ONLY: This student is capable of self-administration and may carry any non-controlled substances and self-administer at school. **YES ☐ NO ☐ (REQUIRES practitioner signature and agreement before valid.)**
- My signature indicates that I have fully read and understand the above information.

_____ _____/_____/_____ _____/_____/_____ _____/_____/_____

Signature of Parent/Legal Guardian (Print name after signature) ***Home Phone or Cell*** ***Business Phone*** ***Date***

PRACTITIONER ORDER: (Please complete for each medication/procedure)

The above medication/procedure is to be administered during the school day in accordance with the above instructions and agreements. I agree to accept communication about student/medication/procedure and understand non-medical, trained school personnel will administer the medication/procedure. Contact me if the following symptoms occur:

_____

SELF CARRY, SELF ADMINISTER – CHOOSE AN OPTION

For any age student-ASTHMA INHALERS AND EPI PENS ONLY: This student and their parents/guardians have been instructed in self-administration and student may carry inhaler or EPI pen and self-administer at school. **YES ☐ NO ☐**

PORTAGE **HIGH SCHOOL STUDENT** NON-CONTROLLED SUBSTANCES ONLY: This student and their parents/guardians have been instructed & shown competence for student to carry any non-controlled substances and self-administer at school. **YES ☐ NO ☐**

_____ _____/_____/_____ _____-_____-_____

Practitioner's Signature ***Date*** *Phone*

_____ _____ _____-_____-_____

Print Name *Clinic Name and Address* *Clinic FAX#*