# SD22 Request for Administration of Medical/Emergency Medication

## A. TO BE COMPLETED BY PARENT OR GUARDIAN

NAME: _____ BIRTHDATE _____
(YR/MONTH/DAY)

PARENT/GUARDIAN _____ HOME TEL _____ BUSINESS TEL _____

PHYSICIAN _____ TELEPHONE _____

## B. TO BE COMPLETED BY PRESCRIBING PHYSICIAN (Conditions Which Make Medication necessary)

NAME OF MEDICATION _____ DOSAGE _____ DIRECTIONS FOR USE _____

1. _____

2. _____

3. _____

4. _____

Emergency Medication:: _____

***If prescribing epinephrine, emergency medication must be a single dose, signle-use auto-injector for the school setting with a second injector that can be given 10-15 minutes if symptoms do not improve. Oran antihistamine will not be administered by school personnel in emergency situations.**

Additional Comments: _____

_____

Physician's Signature Date

## C. TO BE COMPLETED BY SCHOOL PERSONNEL AFTER REVIEWING POLICIES AND CHILD SPECIFIC PLANS (CLASSROOM TEACHERS, ADMIN, CEAS, FIRST AID, SUPERVISORS, NOON HOUR SUPERVISORS)

| DATE | SIGNATURE | PLAN REVIEWED | POLICY REVIEWED |
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