PARENTAL REQUEST FOR DISPENSING MEDICATION
BY UNLICENCED ASSISTIVE PERSONNEL (SCHOOL PERSONNEL)
IN SCHOOL SETTING

Note: Before medication can be given at school, this form must be completed by parents/guardian and medical provider, returned to school, then approved by the school nurse; at which time the task can be delegated to a trained UAP.

The undersigned, parent(s) or legal custodian(s) of ___________________________________, a student at the _______________________________ School in Wasatch County School District, Utah, hereby request(s) and authorized(s) the administration of a medication known as ___________________________________________ to this child in accordance with the instructions given by the family Health Care Provider. I (We) certify that this child requires the administration of this medication for (medical purpose) _________________________ according to the instructions of the prescribing health care provider on the following sheet(s).

The undersigned represent(s) that he/she (they) understand that school employees are not medically trained personnel and that a school nurse is not available to give personal nursing attention at all times during the school day.

The undersigned agree(s) to the following conditions:

1. Has read, reviewed and agree to the Wasatch County School District Policy on Medication Administration
2. The prescribing practitioner signing the accompanying request verifies that medication is medically needed during school hours. And will complete a new form yearly and when there are changes in the prescription.
3. School personnel (principle, UAP, and school nurse) are notified immediately of any changes in the medication or dose.
4. There is a willing UAP(s) to administer the medication and is able to comply with the training and follow-up training needed throughout the school year by the school nurse.
5. Prescription and/or nonprescription medication is to be brought to school by a parent of custodian (NOT A STUDENT) in its original container appropriately labeled by the pharmacy. Stating the name of the student, doctor, pharmacy, and medication, the dosage, time of day to be given, method of administration, and the date of the prescription.
6. The medication is supplied in sufficient quantity so there is no interruption in dispensing medication.
7. Ensure that medication will not expire during the month or throughout the school year.
8. That your child is responsible and is mentally capable of coming to the office and receives the medication.
9. Parent/Guardian(s) will provide the needed medication the child will need throughout the school year.
10. Parent/Guardian(s) will be responsible to pick up any unused or expired medication during the school year and at the end of the school year.

Parent/Guardian Request/Approval:
I hereby request and give my permission for the above named student to receive the specified medication in accordance with the instructions of the Health Care Provider on the reverse side of this sheet. I understand that a non-medical or Unlicensed Assisted Personnel (UAP) will be administering only the medication/s described above to my child at school. If the prescription is changed, a new form will be completed by the parent/guardian and the health care provider before the new medication can be administered.

I further understand that the UAP providing assistance (administration of specified medication so noted) or employer of such staff are not liable, civilly or criminally, for any adverse reaction suffered by medication in keeping with the procedure outlined above.

As parent/guardian of the above named student, I give permission for communication between the prescribing health care provider, the school nurse, the school medical advisor and/or school-based clinic providers necessary for management and administration of medication. I understand that the information contained in this plan will be shared with school staff on a need-to-know basis and that it is the responsibility of the parent/guardian to notify school staff whenever there is any change in the student’s health status or care.

Signature of Parent/Guardian:______________________________________________ Date:____________________

School Nurse ________________________________ Date Noted _______________ Approved? YES ____ NO____
Authorization of School Personnel to Administer Medication

Child’s Name: ___________________________ Date of birth: ____________ Date: ____________

Parent/Guardian: ________________________ Address: __________________________

Phone #’s Home: ________________________ Cell: ________________________ Work: ________________________

Emergency Contact: ____________________ Phone #: ________________________

School: ________________________ School Year: ______ Grade: _______ Teacher: ______________

Medical Diagnosis:

Allergies:

**PHYSICIAN OR HEALTH CARE PROVIDER INFORMATION:** please print

<table>
<thead>
<tr>
<th>Physician Name/Health Care Provider</th>
<th>Phone Number</th>
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Name of Practice and Address

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<thead>
<tr>
<th>Medication</th>
<th>Dose or Amount Given</th>
<th>Route or How Given</th>
<th>Time</th>
<th>Needed or Given For</th>
<th>Duration (Week, month, indefinite, etc.)</th>
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Potential side effects of these medications

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<th>Additional instructions for the school</th>
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I am aware that an Unlicensed Assisted Personnel (UAP) will administer this medication, and in my opinion, this medication is necessary during school hours.

SIGNATURE of Licensed Health Care Provider ___________________________ Date: ____________