LOGOS ACADEMY

Administration of Medication

School year: _____

Logos Academy requests that medication be given before or after school hours whenever possible. We recognize that there are times when this is not possible. If it is essential that your child receive ANY medication(s) during school hours, the following information MUST be completed by you and a licensed prescriber before the medication can be given.All medication must be in original, pharmacy labeled prescription container, **hand-delivered by the parent/guardian to the school**.
Note: Logos Academy does not have a nurse on-site

Student Name:_____ Birth date: _____

Doctor's Name:_____ Doctor's phone # _____

Section 1 "Consent to administer medication" (To be completed by a parent/guardian)

I give my permission for my student to receive the following medication ordered by a licensed prescriber during the school day. I understand that the medications will be given by school personnel according to my child's licensed presciber's instructions.

Parent/guardian signature_____ Date_____

Parent/guardian printed name_____ Phone_____

I request this student be allowed to carry and self administer his/her asthma inhaler ___ yes ___ no

Section 2 "Medication Order" (To be completed by a licensed prescriber)

Medication_____ Dose_____ Frequency_____

Diagnosis/reason for medication_____

Special instructions_____

Licensed prescriber signature_____ Date_____

I request this student be allowed to carry and self administer his/her asthma inhaler ___ yes ___ no
As the health care provider for this student, I verify that he/she has been taught proper use of his/her inhaler and has adequate knowledge of their symptoms and is responsible enough to carry and use their medication properly without supervision.
Licensed prescriber signature_____

Fax number_____

LOGOS ACADEMY

Administración de medicación (Administration of Medication) School year: _____

Logos Academy solicita que se administren medicamentos antes o después del horario escolar siempre que sea posible. Reconocemos que hay momentos en que esto no es posible. Si es esencial que su hijo reciba CUALQUIER medicamento (s) durante el horario escolar, usted y un recetador autorizado DEBEN completar la siguiente información antes de que se pueda administrar el medicamento. Todos los medicamentos deben estar en el envase original de la receta etiquetado en la farmacia, entregado personalmente por el padre / tutor a la escuela.
Nota: Logos Academy no tiene una enfermera en el lugar

Student Name:_____ **Birth date:** _____

Doctor's Name:_____ **Doctor's phone #** _____

Sección 1 "Consentimiento para administrar medicamentos" (Para ser completado por un padre / tutor)
Doy mi permiso para que mi estudiante reciba el siguiente medicamento ordenado por un recetador autorizado durante el día escolar. Entiendo que los medicamentos serán administrados por el personal de la escuela de acuerdo con las instrucciones del perscriber con licencia de mi hijo.

Parent/guardian signature_____ Date_____

Parent/guardian printed name_____ Phone_____

Solicito que se permita a este estudiante llevar y auto administrarse su inhalador para el asma ___ sí ___ no
(I request this student be allowed to carry and self administer his/her asthma inhaler ___ yes ___ no)

Sección 2 "Orden de medicación" (Para completar por un recetador autorizado) To be completed by licensed prescriber

Medication_____ Dose_____ Frequency_____

Diagnosis/reason for medication_____

Special instructions_____

Licensed prescriber signature_____ Date_____

I request this student be allowed to carry and self administer his/her asthma inhaler ___ yes ___ no
(Solicito que se permita a este estudiante llevar y auto administrarse su inhalador para el asma ___ sí ___ no)
As the health care provider for this student, I verify that he/she has been taught proper use of his/her inhaler and has adequate knowledge of their symptoms and is responsible enough to carry and use their medication properly without supervision.
Licensed prescriber signature_____

Fax number_____