WAKE CHRISTIAN ACADEMY

Parent Request and Physicians' Order Form for Medication

Student Name:		**DOB:**	**Grade:**	**School Year:**	
	Diagnosis	Name of Medication (Right Medication)	Dosage (Right Amount)	How to give (Right Route)	Time(s) to Give (Right Time)
Daily Medication(s)	☐ ADHD ☐ Cystic Fibrosis ☐ Seizure ☐ Diabetes ☐ Other: _____				
Emergency Medication(s)	Allergy Allergen: ________________	☐ Diphenhydramine (Benadryl)	☐ 12.5 mg ☐ 25 mg ☐ Other: __________	By Mouth	☐ Upon Exposure ☐ Mild Reaction
		☐ Epinephrine Auto Injector	☐ 0.15 mg ☐ 0.3 mg	Intramuscular (IM)	☐ Upon Exposure ☐ Severe Reaction ☐ If provided, repeat dose after ___ min. for continued symptoms.
	Seizures	☐ Diastat Gel	☐ 5.0 mg ☐ 7.5 mg ☐ 10.0 mg ☐ ______ mg	Rectal	☐ At onset of seizure ☐ After 5 minutes ☐ After 10 minutes
	Diabetes	☐ Glucagon	☐ 0.5 mg ☐ 1.0 mg	☐ Subcutaneous (SQ) ☐ Intramuscular (IM)	If student becomes unconscious
Asthma	Exercise Induced Asthma	☐ Albuterol ☐ Xopenex	☐ 2 puffs ☐ 1 vial (ampule)	☐ Inhaler with spacer, if provided ☐ Nebulizer	Before exercise, as needed, to prevent symptoms
	Asthma Yellow Zone	☐ Albuterol ☐ Xopenex	**Please check one** ☐ 2 puffs ☐ 4 puffs ☐ 1 vial (ampule)	☐ Inhaler with spacer, if provided ☐ Nebulizer	☐ Every 4 hours, as needed, to relieve symptoms ☐ ______________________
	Asthma Red Zone		**Call 911** ☐ 4 puffs ☐ 1 vial (ampule)	☐ Inhaler with spacer, if provided ☐ Nebulizer	**For Emergency Symptoms**
As Needed PRN Meds					

Physician's Printed Name: ______________________________ Date: _________________ Telephone: ____________________

Physician's Signature: __________________________________ Date: _________________ Fax: ____________________

WAKE CHRISTIAN ACADEMY

To be completed by parent/gaurdian.

I understand that:

- The school nurse or authorized school personnel will conduct the administration of medication.
- It is my responsibility to have an adult transport the medication to school.
- If the medication is not available at the school, 911 will be called for emergencies.
- If my child participates in before/after-school activities/sports, I will assume responsibility for contacting the advisor/coach of my child's medical condition. I will provide extra emergency medications that may be needed during the activity. I may contact the school nurse if assistance is needed in instructing the advisor in a medical procedure or if a copy of the information needs to be shared with them.

I request that:

- My child be administered the medication as indicated in the physician's order.
- If an emergency injection is ordered, I give permission for the school nurse to instruct designated staff in the administration technique.

I authorize:

- The release and exchange of medical information between my child's physician, school nurse and Wake Christian Academy that is necessary in carrying out services for my child.

I hereby give my permission for my child to receive medication during school hours. This medication has been prescribed by a licensed physician.

Parent/Gaurdian Signature: ____________________________________ **Date:** ______________ **Phone:** _____________________

Rev 12/06/2016