TEACHWELL SOLUTIONS

Medication Administration

EPI-PEN AND INHALER PRESCRIPTIONS

Please have a physician confirm your child's medication needs

If your child needs access to an Epi Pen or an inhaler while at school, Teachwell Solutions needs this form completed at least once per year.

STUDENT AND FAMILY INFORMATION

A parent or guardian completes this section of the form.

STUDENT NAME

FIRST _____ LAST _____

SCHOOL PROGRAM

Please Select

SELECT PROGRAM

DATE OF BIRTH

MM _____ DD _____ YY _____

PARENT OR GUARDIAN NAME

FIRST _____ LAST _____

PARENT OR GUARDIAN PHONE NUMBER

_____

AUTHORIZATION TO SELF-ADMINISTER EPI-PEN OR INHALER PRESCRIPTION

_____ INITIAL — I authorize my child to self-administer medication while at school.

_____ INITIAL — I understand that if an emergency medical situation prevents my child from self-administering medication, a trained medication administration professional will administer the medication.

_____ INITIAL — I relieve the school, its employees and any of its vendors of all responsibility related to the administration of medication.

_____ INITIAL — I give Teachwell Solutions employees and vendors have permission to communicate with my child's prescribing providers to ensure medication can be properly administered.

_____ INITIAL — I understand that prescription medications may only be stored at school during the time the prescription is authorized by a medical professional.

_____ INITIAL — I understand that unused medication will be discarded if not secured by a parent or guardian.

PARENT OR GUARDIAN SIGNATURE _____

DATE

MM _____ DD _____ YY _____

THIS FORM HAS ADDITIONAL PAGES → → → PLEASE CONTINUE → → →

STUDENT MEDICAL CARE INFORMATION (MEDICAL PROVIDER)

This section of the form should be completed by your child's healthcare provider.

PATIENT NAME | **DATE OF BIRTH**

FIRST | LAST | MIDDLE | MM | DD | YY

MEDICAL DIAGNOSIS

PRESCRIPTION MEDICATION | **DOSE**

TIME(S) TO BE ADMINISTERED AT SCHOOL | **METHOD OF ADMINISTRATION**

PRECAUTIONS AND REACTIONS TO OBSERVE

START DATE MM DD YY | **END DATE** MM DD YY

PHYSICIAN AUTHORIZATION AND SIGNATURE

INITIAL The above named child is capable of self-administration of the prescribed medication.

INITIAL I understand that if an emergency medical situation prevents my child from self-administering medication, a trained medication administration professional will administer the medication.

PHYSICIAN SIGNATURE | MM | DD | YY

PHYSICIAN NAME (PRINTED) | CLINIC OR HOSPITAL NAME | PHONE NUMBER

SEND COMPELTED FORM TO:
email | karin.reisch@teachwell.org fax | 605-367-6036
Mailing Address | Teachwell Solutions – 715 East 14th Street, Sioux Falls, SD 57104