Académie Lafayette

As the parent/guardian of _____, I request that the
Please Print Name Clearly
medications listed below that have been authorized by my child's doctor be given by the nurse as prescribed. I understand that this form must be updated at the beginning of every school year and will only be in effect for the current school year of 20_____ to 20_____.

Parent/Guardian signature Date

As the physician for _____, I hereby prescribe the
Please Print Name Clearly
following medications for use at school during the school year of 20_____ to 20_____

Please fill in all blanks for prescribed medications. The school must have complete and accurate orders on file to be able to administer any medication. Thank you.

☐ Ibuprofen _____ mg PO q _____ for _____

☐ Tylenol _____ mg PO q _____ for _____

☐ Inhaler (_____) _____ puffs MDI Q _____ for _____
Type of Inhaler

☐ Permission to carry at school ☐ Permission to self-administer

☐ Nebulizer _____ Inhaled Q_____ for _____

☐ Auto inject EpiPen / EpiPen Jr for reaction to _____
Circle One

☐ Permission to carry at school ☐ Permission to self-administer

☐ Epinephrine _____ ml for allergic reaction to _____

☐ Benadryl _____mg / ml PO Q_____ for _____
Circle One

☐ Permission to carry at school

☐ _____

☐ _____

☐ _____

If the student has Asthma or an Allergy, please attach this year's current Action Plan. This must be updated on an annual basis.

Physician Signature Date

Academie Lafayette Nurse's Office
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Phone: 816-361-7735 Fax: 816-361-5788
Cherry Campus: Mary Ammatelli, RN – email: mammatelli@academielafayette.org
Phone: 816-888-7463 Fax: 816-888-7410