

Form JGCD-9

*Empowering Dreams for the Future*

**HYPODERMIC INJECTION REQUEST**

**From Licensed Health Care Provider (Legal Prescriber)**

|  |  |
| --- | --- |
| Date: |  |

|  |  |
| --- | --- |
| Student’s Name: |  |

|  |  |  |  |  |  |  |
| --- | --- | --- | --- | --- | --- | --- |
|  |  |  |  |  |  |  |

Name of Medication Dosage Route Time

Student requires the injection during school hours.

Student has been instructed by me in the proper use of the above medication. In my professional opinion

|  |  |
| --- | --- |
|  | MAY ADMINISTER this medication himself/herself. |

OR

Student has been instructed by me in the proper use of the above medication. In my professional opinion

|  |  |
| --- | --- |
|  | NEEDS ASSISTANCE from the licensed school nurse. |

Type of assistance student requires for administering medication (observe, measure, etc.):

|  |
| --- |
|  |

Discontinue medication on:

Special instructions:

|  |
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|  |

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| --- | --- | --- | --- |
| Printed Name of Legal Prescriber: |  | Phone: |  |

Signature of Legal Prescriber:

***Please note: One medication per form***