REQUEST FOR ADMINISTRATION OF MEDICATION
*This request must be renewed annually or sooner if condition warrants.

School personnel **may agree** to honor parent requests for the administration of medication to students. Any medication sent to school without proper identification will not be given. All medication must be in the **original container and if prescribed by a health provider, must** indicate the following information: student name, dosage, physician, pharmacy, date issued, and prescription number.

Medication Type: (Check type)
- [ ] Over the Counter Medication
- [ ] Prescription (The completed Health Care Statement below or a written statement signed and dated by the health care provider supporting this request is required for all prescribed medication.)

<table>
<thead>
<tr>
<th>PARENT STATEMENT:</th>
</tr>
</thead>
<tbody>
<tr>
<td>I hereby request that __________ medication be given to my child, ________________.</td>
</tr>
<tr>
<td>(Name of medication) (Student’s Name)</td>
</tr>
<tr>
<td>I understand that the school is not legally obligated to administer medication to my child, but school personnel will administer the medication, if needed. I agree to defend and hold the school district employees harmless from any liability for the results of the medication or the manner in which it is administered, and to defend and indemnify the school district and its employees for any liability arising out of these arrangements. I will notify the school immediately if the medication is changed.</td>
</tr>
<tr>
<td>Signature of Parent/Guardian: ___________________________ Date: ____________</td>
</tr>
<tr>
<td>Home Phone: ___________________________ Work/Cell Phone: ___________________________</td>
</tr>
<tr>
<td>List any other medications your child is taking:</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>HEALTH CARE PROVIDER STATEMENT (Complete this section for prescribed medication only)</th>
</tr>
</thead>
<tbody>
<tr>
<td>_______________ must receive medication during school hours for ________________.</td>
</tr>
<tr>
<td>(Student’s Name) (Condition)</td>
</tr>
<tr>
<td>This medication must be given during school hours in order to maintain sufficient health and participation in the school program.</td>
</tr>
</tbody>
</table>

**Medication Administration Information**

| Medication: |
| Dosage: |
| Frequency: |
| Possible Side Effects: |

| Health Care Provider’s Signature: ___________________________ Date: ____________ |
| Health Care Provider’s (printed): ___________________________ |
| Address: ___________________________ Phone: ___________________________ |

**Office Only:**

Bldg. BES KGH BMS SHS PHS REACH

Please give to District Nurse for signature before filing.

| Nurse’s Signature: ___________________________ Date: ____________ |
AUTHORIZATION, RELEASE AND INDEMNIFICATION FOR STUDENT’S SELF-ADMINISTRATION OF MEDICATION

*This request must be renewed annually or sooner if condition warrants.

BY SIGNING THIS FORM YOU AGREE TO RELEASE THE DISTRICT FROM ANY AND ALL LIABILITY THAT MAY RESULT FROM YOUR CHILD’S SELF-ADMINISTRATION OF MEDICATION.

Child’s Name: ________________________________ Date of Birth: ________________

Grade: ______________________

I, ________________________________, consent for my child to self-administer the medication listed below in the manner prescribed by his/her physician in the attached medical authorization.

Medication: ________________________________

Dosage: ________________________________

Frequency: ________________________________

By signing this consent form, I agree to release, indemnify, hold harmless, and defend the school, its employees or agents from and against any and all claims, losses, damages, costs, actions, judgments, expenses and liabilities of every kind and nature whatsoever, that are in any way connected with, arise from, or are claimed to arise from, the self-administration or storage of my child’s medication.

____________________________________________
Parent/Guardian (print name)

____________________________________________
Signature

__________________________
Date

Office Only:
Bldg. BES KGH BMS SHS PHS REACH
Please give to District Nurse for signature before filing.

Nurse’s Signature: ________________________________ Date: ________________
AUTHORIZATION FOR THE POSSESSION AND SELF-ADMINISTRATION OF MEDICATION REQUIRED TO TREAT
ASTHMA OR ANAPHYLAXIS

This form is to be filled out by your child’s health care provider.

*This request must be renewed annually or sooner if condition warrants.

__________________________________________________________________________ has been prescribed the medication listed below.

(Child’s name)

Medication: __________________________________________________________________

Dosage: ____________________________________________________________________

Frequency: __________________________________________________________________

Administration of this medication is required for treatment of the child’s ______________________________.

(Medical condition)

I have instructed _________________________

(Child’s name)
on the proper method of self-administration of the medication, and am satisfied that he/she has the skill level
necessary to self-administer the medication and to use any device needed to administer it. The medication
and any device needed for its administration should be handled as indicated below:

☐ Stored with the school nurse or other designated school official and self-administered in their
   presence.

☐ Kept in the child’s possession and self-administered as needed.

__________________________________________________________________________

Physician’s name (print)                                      Telephone number

__________________________________________________________________________

Signature                                      Date

Office Only:

Please give to District Nurse for signature before filing.

Nurse’s Signature: ________________________________                             Date: ________________