REQUEST FOR ADMINISTRATION OF MEDICATION

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. Medication must be in the original container indicating the following information: student name, dosage, physician, pharmacy, date issued, and prescription number. This form or a written statement signed and dated by the health care provider supporting this request is required for all medication.

PARENT STATEMENT: School:__________________________

I hereby request that_______________ medication be given to my child, ______________________ I understand that the school is not legally obligated to administer medication to my child, and in the absence of the school nurse, other school personnel will administer the medication. 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.

Signature of Parent/Guardian:__________________________ Date:__________________________

Home Phone:_______________ Work/Emergency Phone:__________________________

Name any other medications your child is taking:____________________________________

____________________________________

HEALTH CARE PROVIDER STATEMENT:

_______________ must receive medication during school hours for the following condition:__________________________

This medication must be given during school hours in order to maintain sufficient health and participation in the school program.

Name and duration of medication:____________________________________________________

Prescribed daily dosage:____________________________________________________________

Time and dosage to be given in school:________________________________________________

Beginning date of medication:_______________ Ending date:__________________________

Possible side effects:_______________________________________________________________

Health care provider’s signature:_______________ Date:_______________

Health care provider’s printed name:____________________ Phone:_____________________

Health care provider’s address:____________________________________________________