SITKA SCHOOL DISTRICT
Health Services

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:_____
(Student's Name)

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:_____