Request for Medication to be Given During School Hours

To be completed by physician

Name of Student _____ School _____

Medication_____ Dosage _____
(No injection will be given except in the case of an extreme emergency)

Time(s) medication is to be given: a.m._____ p.m. _____ To be given from (date) _____ to _____

Significant Information (include side effects, toxic reactions, omission reactions: _____
_____

Contraindications for Administration: _____
_____

If an emergency situation occurs during the school day, or if the student becomes ill, school officials are to:

Contact me at my office _____ Telephone _____

Take child immediately to the emergency room at _____

Other option: _____

This medication will be furnished by parent or guardian within a container properly labeled by a pharmacist with identifying information (e.g., name of the child, medication dispensed, dosage prescribed, and the time it is to be given).

_____ DEA#_____ Date _____
Physician's Signature

PARENT PERMISSION

I hereby give my permission for my child (named above) to receive medication during school hours. This medication has been prescribed by a licensed physician. I hereby release the School Board and their agents and employees from all liability that may result from my child taking the prescribed medication.

_____ _____ _____
Parent or Guardian Signature Telephone Number Date

(School Use Only)

Name and title of person to administer medication _____

Approved by: _____ _____
Principal's Signature Date

Reviewed by: _____ _____
School Nurse's Signature Date