



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).

Physician's Signature DEA# _____ Date _____

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