REQUEST FOR MEDICINE TO BE GIVEN DURING SCHOOL HOURS

To be completed by physician

Name of Student_____ Date of Birth_____

School_____

Medication_____ Dosage_____

(No injection will be given except in extreme emergencies: such as allergy to wasp or bee stings.)

Time(s) medication is to be given: am_____pm_____ To be given from date_____ to _____

Significant information (include side effects, toxic reaction, and omission reaction): _____

_____

_____

Contraindications for
Administration:_____

_____

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

A. Contact me at my office _____ Phone #_____

B. Take child immediately to the emergency room at _____

C. Other options_____

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 time it is to be given).

_____ _____ _____

Physician's Signature DEA# Date

PARENT'S PERMISSION

I hereby give my permission for my child (named above) to receive medication during school hour. A licensed physician has prescribed this medication. 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/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 Signature Date

Adopted: July 1, 2009