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REQUEST FOR MEDICINE TO BE GIVEN DURING SCHOOL HOURS

To be completed by physician

Policy Code 6125-E-1

Name of Student _____ Date of Birth _____

School _____

Medication _____

Dosage and Route: _____

(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_____ PRN_____

To be given from (date) _____ to/through _____

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 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 hours. 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

Updated: 9/2017