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:
_____Contact me at my office___________________________________Phone#_________________

_____Take child immediately to the emergency room at ___________________________________

_____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 Date DEA #

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 Date