Parent's Request for Administration of Medication at School

Date:_____

Student Name:_____ DOB:_____Grade:____ Teacher:_____

☐ **For prescription and over the counter medication given by school personnel**

Top portion to be completed by health care provider; bottom portion to be completed by parent/guardian.

Medication	Dose	Time	Route	Side Effects	Adverse Reactions

StartDate:_____StopDate:_____

List minimal frequency between doses (especially if p.r.n-as needed):_____

If p.r.n, list symptoms/conditions under which medication is to be given:_____

Physician's Phone #: _____ Fax#:_____

Address_____

_____ _____ _____

physician's signature | date | physician's printed name

To be completed by parent/guardian:

I request and give permission for my child (named above) to receive the above medication (prescription or over the counter-OTC) according to the prescribing health care provider's prescription OR direction for OTC AND school district policy. I also give permission for the health care provider('s)/ staff and school district staff to share information regarding my child's medication needs. I understand that the medication must be in the original pharmacy/over the counter medication container, labeled with student's name, **and if prescribed medication:** with name of prescribing health care provider, strength and dose of medication, and directions for use. I will assume responsibility for safe delivery of the medication to school. I will notify the school immediately if there is any change in the use of the medication or treatment. I release and agree to hold the Board of Education, its officials, and its employees harmless from any and all liability foreseeable or unforeseeable for damages or injury resulting directly or indirectly from this authorization.

_____ _____ _____ _____

parent/guardian signature | date | student signature | date

For your child's safety with routine daily medication, he/she should receive at least the first dose of medication at home so you may observe him/her for signs and symptoms of adverse or allergic reactions.

☐ initial my child has received at least one dose of this medication at home.