

REQUEST FOR SCHOOL TO ADMINISTER MEDICINE

As the parent/guardian of _____ ,
(PLEASE PRINT) (Student's Last Name) (Students First Name)

request that a school staff member give medication to my child. I agree that instructions for giving non-prescription medicine must be given by me, in writing, in order for school staff to give medicine. Any prescription medication that I request be given, will be provided to the school in the original container as dispensed by the pharmacy (no baggies, foil, etc.), labeled with my child's name along with the following instructions:

Name of Medication: _____

Time to be given: _____ Amount/Dose to be given: _____

Child's Medication Allergies: _____

Circle one: Prescription Non-Prescription

If Prescription Medicine:

a. Condition/Illness Requiring Medication: _____

b. Physician's Name _____ Physician's Phone _____

c. Date Prescribed: _____

I further agree that no school employee shall be held liable in any way for any side-effects or medical problems resulting from the school employee's giving my child medications as directed by the doctor's order(s) or as directed by me as the child's parent/guardian. I also will be responsible for informing the school of any changes to the medications requested above.

(Parent/Guardian Signature) Date: _____

Parent's Name: _____
(PLEASE PRINT)

Daytime Phone#: _____ Pgr/Cell#: _____



To be completed by School Nurse/ Clinician only:

Rec'd Date _____ Medicine _____ Doses _____