

REQUEST FOR SCHOOL ADMINISTRATION OF MEDICATION

PART I – TO BE COMPLETED BY A LICENSED HEALTH CARE PROVIDER

1. Name of Student _____ 2. Address _____

3. School Building _____ Grade: _____

4. Name of medication to be administered or procedure requested: _____

Quantity (dosage) _____ Times _____ Date to Begin _____

5. Possible reactions that might occur which should be reported to the Health Care Provider _____

6. Special instructions, if required (administration of drug, sterile conditions, storage, etc.) _____

* 7. Medication to be continued as above until (Date) _____

8. LICENSED HEALTH CARE PROVIDER: Name _____

Address _____

Phone # _____ Emergency Phone # _____

SIGNATURE _____ **DATE** _____

*** Medication is to be picked up from the clinic by the last day of school or it will be disposed of by school personnel.**

PART II – TO BE COMPLETED BY PARENT OR GUARDIAN

We (I) understand that the administration of said medication is to be done under the supervision of a member of the adult school staff.

Further, we (I) understand that the school personnel are not legally obligated to administer oral medication to any child and therefore, we (I) agree to hold the School District and its employees free from any and all responsibility for the results of such medication or the manner in which it is administered and to indemnify each of them against loss by reason of any civil judgment arising out of these arrangements which may be rendered against them.

Further, we (I) agree to deliver the medication to the school in the original container from the prescribing Health Care Provider or Licensed Pharmacist, properly labeled by same, this label to include name of student, Health Care Provider, date, dosage instructions (quantity and times) and name of medication.

Further, we (I) will notify the school immediately if we change Health Care Providers or medication or terminate the use of this medication for any reason, and will report immediately to the school to pick up the remainder of said medication.

1. SIGNATURE OF FATHER OR GUARDIAN: _____ Date _____

2. SIGNATURE OF MOTHER OR GUARDIAN: _____ Date _____

3. Home Phone _____ Address _____ Work Phone _____

PART III – TO BE COMPLETED BY THE SCHOOL

1. Signature of Clinic Assistant _____ Date _____

2. Reviewed by School Nurse: _____ Date _____

3. Signature of Principal: _____ Date _____

RETURN THIS FORM TO THE SCHOOL NURSE