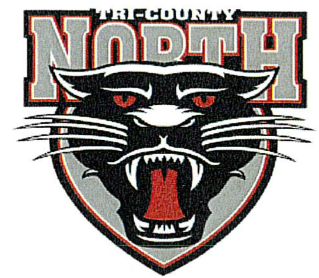
Administration of Prescription Medication at School



The following information is necessary for any student to use prescribed medications or to receive treatment in school.

Name of Student	Date of Birth	School Year
Address		Homeroom Teacher

A. I am requesting permission for my child named above to use or receive prescribed medication.

B. I will assume full responsibility for safe delivery of the medication to school. The medication must be received by the school in the original package as dispensed by prescriber or a licensed pharmacist.

C. I will notify the school immediately if there is any change in the use of the medication or the prescribed treatment. (You must submit a revised form, signed by the prescriber, if any of the information contained in this statement changes.)

D. I release and agree to hold the Board of Education, its officials, and its employees harmless from any and all liability foreseeable for damages or injury resulting directly or indirectly from this authorization.

___________________ Parent/ Guardian Signature ___________________ Phone Number

The School District requires all of the following information be provided before the medication or treatment is administered to the student.

Name of medication:____________________ Dosage:____________________

Route:____________ Time and Frequency to administer:____________________

Date the administration is to: Special instructions for administration:

Begin:____________ ____________________

End: ____________ ____________________

Possible reactions that, if occur, should be reported to the physician:____________

____

I am a licensed health care professional authorized to prescribe drugs, and I have prescribed the listed medication to the above named student.

Physician's Signature	Address/ Phone Number	Date

Disclaimer: The School District has the right to determine if a medication is appropriate for use in the school environment. This form is valid for one (1) school year.