REQUEST FOR MEDICATION TO BE ADMINISTERED AT SCHOOL DURING SCHOOL HOURS

D.O.B _____

Name of Student_____ Grade_____

School_____ Teacher_____

Medication #1_____ Dosage_____

Medication #2_____ Dosage_____

Medication #3_____ Dosage_____

Date Medication Started_____ Reason for Meds_____

Time of Day to be Given_____

Anticipated Number of Days to be Administered at School_____

Date_____ Physician Signature_____

I hereby give my permission for _____ to take the above medication prescription at school as ordered. I understand that it is my responsibility to furnish this medication. I further understand that any school employee who administers any drug to this student in accordance with written instructions from the physician or dentist shall not be liable for damages as a result of an adverse drug reaction suffered by the student because of administering such drug. **I also give permission for the exchange of information between the school nurse/other school representative and the prescribing physician/pharmacy should a question or concern arise.**

Date_____ Signature of Parent or Guardian_____

NOTE: The medication(s) is to be brought to school in the original container appropriately labeled by the pharmacy or physician, stating the name of the medication, the dosage, time of day to be given and anticipated number of days to be administered at school.