

Request for Medication to be Given During School Hours

I. To be completed by physician

Student _____ Date of Birth _____

Medication _____ Dosage _____

(NO injection will be given except in extreme emergency, such as allergy to wasp or bee sting)

Time(s) medication is to be given _____ AM _____ PM _____

To be given from (dates): _____ to _____

Significant information (include side effects, toxic reactions, omission reactions): _____

Contraindications for administration: _____

If an emergency situation occurs during the school day or if the student becomes ill, school officials are to:

a. Contact me at my office: _____ Phone: _____

b. Take child immediately to the emergency room at: _____

c. Other option: _____

This medication will be furnished by parent/guardian within a container properly labeled by a pharmacist with identifying information (e.g. name of the child, medication dispensed, dosage prescribed, and the time it is to be given).

Physician's signature: _____ Date: _____

II. To be completed by parent

I hereby give my permission for my child (named above) to receive medication during school hours. This medication has been prescribed by a licensed physician. I hereby release the Board of Education and their agents and employees from any and all liability that may result from my child taking the prescribed medication. I understand that the law states that school employees who administer medications at school will only be held liable for gross negligence "in the performance of this duty."

Signature of parent/guardian: _____ Date: _____

Telephone: _____

III. To be completed by school

Name of person to administer medication: _____ Title: _____

Approved by: _____ (Principal) _____ Date: _____

Reviewed by: _____ (Public Health Nurse) _____ Date: _____