REQUEST FOR MEDICATIONS TO BE ADMINISTERED IN SCHOOL

Name of Pupil: _____ Grade: _____ DOB: _____

Address: _____ Parent(s)/Guardian: _____

Emergency Telephone Number(s): _____

Medication: _____

Dosage: _____

Time/Circumstances of Administration: _____

Purpose/Diagnosis: _____

Duration: _____

Restrictions: Physical Education Yes _____ No Restrictions _____

If yes, how long _____
Other _____

Physician's Name (Please Print) _____

Address: _____

Telephone Number: _____

Physician's Signature: _____ Date: _____

PUPIL SELF ADMINISTRATION OF MEDICATION (PHYSICIAN'S CERTIFICATION)

I certify that the above named pupil is capable of and has been instructed in the proper use/method of administration and must be in possession of medication (as described above) at all times.

PHYSICIAN'S SIGNATURE _____ DATE_____

Parent/Guardian Consent

The school nurse at _____ School has permission to administer the above medication to my child as prescribed by physician. We/I give permission to the school nurse to contact the physician if necessary. We/I also acknowledge that the district or its employees shall incur no liability as a result of the administration of medication by the above medication or injury arising from the self-administration of medication by the pupil and indemnify and hold harmless the district and its employees or agents against claims arising out of self-administration of medication by my child.

Parent/Guardian Signature: _____ Date: _____