Request for Medication To Be Administered During School Attendance in USD #321

Name of Student____

School____ Grade_______________

Teacher____

Medication_______________________________________ Dosage_______________

Date Medication started________________ Reason for RX_______________________

Time of day Medication is to be given____

Anticipated number of days to be administered at school____________________________

If using an inhaler, is student able to keep at desk/locker and self-administer as needed?
Yes____ No____

Date_______________ ____
Signature of Physician

I hereby give my permission for ___________________________ to take the above prescription at school as ordered. I confirm that my child has taken at least one dose of this medication without an allergic reaction. I understand that it is my responsibility to furnish this medication to the school. I further understand that any school employee who administers any drug to my child 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 the above drug.

**Would you like to be notified if your child's "as needed" medication is administered at school? Yes___ No___ Phone____________

Notes____

Date ___________ _____________________________________
Signature of Parent or Guardian

NOTE: The medication 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 and the number of days to be administered at school.

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