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: _____

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 (PHYSICAN'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 of 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 any claims arising out of the self –administration of medication by my child.

Parent/Guardian Signature: _____ Date: _____