

Request for Medication to be Administered During School Attendance

Name of Student _____

School _____ Date of Birth _____ Grade _____

Medication _____ Dosage _____ Route _____

Date Medication Started _____ Reason of RX _____

Time of day medication is to be given _____

Anticipated number of days to be administered at school _____

Date

Signature of Physician

I hereby give my permission for _____
to take the above 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 my student in accordance with written instructions from the prescribing provider shall not be liable for damages as a result of an adverse drug reaction suffered by the student because of administering such drug. I give authorization for the school nurse to communicate with the prescribing provider to ensure continuity of care.

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.