Germantown
SCHOOL DISTRICT

Empower and Inspire Every Student to Success

PARENTAL REQUEST FOR ADMINISTRATION OF PRESCRIBED MEDICATION

Date: _____ **School:** _____

Student Name:_____ is in need of medication during school.

Name of Medication: _____ **Reason for Medication:** _____

Dosage: _____ **Time of Administration:** _____

How to be Given (i.e. with water, with food): _____

Physician: _____ **Clinic:** _____

Physician Phone: _____ **Fax:** _____

Parent/Guardian Name AND Phone Number: _____

Parent/Guardian Initials

_____I give permission to school staff, designated by the principal, to administer the listed medication on this form (one medication per sheet). It is my understanding medication will be administered under the general supervision of a district designated health care professional.

_____I give permission for the school staff, including the district designated health care professional, to contact my child's physician with any concerns regarding medication administrations.

_____I give the school staff, including the district designated health care professional, permission to call me with any concerns regarding medication administration.

_____I agree to supply the school with no more than a four week supply of medication. (Medication is to be delivered to the school office by parent or parent designated adult only) I will notify the school in writing at the termination of request for medication administration, or of any change in directions of administration.

_____Prescription medication will be supplied in a pharmacy labeled container. The label will have the child's name, drug name, dosage, and how often to be taken. Also, the name of the prescribing physician will be on the label, along with the pharmacy name and phone number.

_____I understand I cannot send prescription medications to school with my child. The parent, or a responsible adult designated by a parent, is expected to deliver any necessary medications to their child's school. An exception to this rule might be made only if the parent has requested approval for student self-administration of medication and the request has been approved by the building principal.

I understand that no medication will be administered by the school without full compliance of the above stated terms and conditions. (Physician signature is required for all prescribed medication)

_____ _____

Parent/Guardian Signature **Date**

_____ _____

Physician Signature **Date**