PARK COUNTY SCHOOL DISTRICT 6
BOARD OF EDUCATION POLICY

JLCD-E2

REQUEST FOR ADMINISTRATION OF MEDICATION
PRESCRIPTION ONLY

Student's Name:__________________________ Date of Birth:__________________

School:______________________________ Grade:______________________

TO BE COMPLETED BY PHYSICIAN:

Diagnosis:____

Rx (Dosage/Frequency/Route):______________________________

Reportable Adverse Reactions/Side Effects:________________________

____

Beginning Date:____________________ Ending Date:____________________

List Other Medications Currently Being Taken:________________________

____

Name of Prescribing Physician:__________________________ Date:______________
Please Print

Physician's Signature:______________________________

The medication must be in its original manufacturer's container, box or bottle stating the name of the student and dosage.

I request that the Principal or his/her designee administer the medication as directed above. I understand that it is my child's responsibility to report to the office for this service. I authorize the release of information between the school and physician pertinent to my child's medication.

Parent/Guardian Signature	Date	Phone #	Emergency #

INHALER/EPI-PEN EXCEPTION:
My child has been instructed in the proper use of the above medication. I request that he/she be permitted to carry and self-administer the medication. PCSD #6 will assume no responsibility or liability for the self-medication by a student or for the medication carried by the student.

Parent/Guardian Signature	Date