MCHS HEALTH OFFICE

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REQUEST FOR STUDENT TO RECEIVE MEDICATION IN SCHOOL

All Students needing scheduled or as-needed medication in the school must submit this completed form to the School Nurse. A new form is required each school year. All medications must be in their original container.

Student's Name: _____ **Birth Date:** _____

Prescriber Medication Information and Authorization

To be completed and signed by the student's physician, physician assistant, or advanced practice registered nurse.

Medication	Dosage	Time	Frequency	Route	Reason

Prescriber's Name: _____ Phone: _____

Address: _____ Fax: _____

Prescriber's Signature: _____ Date: _____

PARENT/GUARDIAN CONSENT FOR SCHOOL TO ADMINISTER MEDICATION

I agree to indemnify and hold harmless the School District and its employees against any claims, except ones based on willful/wanton conduct, arising from the administration of medication. Responsibility of the parent/guardian notifying the school of any changes in health and providing physician's documentation of changes in medication orders has been disclosed. I understand the student's responsibility to report to medication appointments with the School nurse and that the prescriber should initially educate the student in the management of the condition.

Please sign to indicate (a) receipt of this information, and (b) authorization for the school to administer their medication.

Parent/Guardian Printed Name: _____ Emergency Phone: _____

Signature: _____ Date: _____