USD #415 SCHOOL DISTRICT

PERMISSION FOR MEDICATION

(REQUESTING AUTHORIZED STAFF TO ADMINISTER MEDICATION TO STUDENT)

Name of Student ____ DOB ____________________

School ____ Grade _________________

Teacher(s) ____

Medication ____ Dosage ________________

Date Medication to start at school ________________ Diagnosis/Reason for RX _________________

_______Initial dose was given at home with no adverse reactions (please check if yes)

Time of day medication is to be given at school ____

Expected duration of RX ____

_____________________ DATE

_____________________________________ PHYSICIAN SIGNATURE

_____________________________________ PHYSICIAN NAME (PRINT)

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I hereby give my permission for _________________________________ to take the above prescription at school as ordered. I verify that my student has previously had at least one dose of the above prescribed medication and did not have an adverse reaction from it. 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 physician or dentist shall not be liable for damages from an adverse drug reaction suffered by the student as a result of administering such drug or because of mislabeled or altered products. I hereby authorize USD #415 personnel to exchange information regarding this request with the above-named physician and with the pharmacy as identified on the affixed pharmacy label.

_____________________ DATE

_____________________________________ PARENT/GUARDIAN SIGNATURE

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 times to be administered.