Request For

ADMINISTRATION OF MEDICATION

Student's Name____
School____________________ Age______ Grade______ Teacher_____________

TO BE COMPLETED (IN FULL) BY PHYSICIAN:

Disease or illness of student____
Name of drug to be given____
Dosage/Time/Frequency to be given at school_________________________
Action of drug____
Side effects of drug____
Times administered at home____
Minimum time between doses____
This drug is to be administered:
Until the end of the current school year_________ Other__________

Can the student carry his/her own inhaler? YES_____ NO_____
Can the student carry his/her own Epi-Pen? YES_____ NO_____
*****Please note that we would like to have an extra inhaler/Epi-pen to be kept in the nurse's office in the event that the student would misplace or forget his/her medication.**

1. The above-named medication is to be brought to school in a container appropriately labeled by the pharmacy or physician. Over-the-counter medications can be labeled by the parent. This container must duplicate the directions given on this request.
2. Parents must pick up medication from their child's school. No medications will be sent home with students.

By signing this, I, the parent, understand that I am releasing Marshall Community Unit School District #C-2 and the employees of any liability while following the above request.
Marshall Schools may_____ or may not_____ contact the physician or pharmacy regarding any questions about the above-listed medication.

Parent Signature____________________________ Date____________________
Doctor's Signature___________________________Date____________________
Doctor's Name and Address____
Doctor's Telephone Number____