EASTON VALLEY
COMMUNITY SCHOOLS
www.EastonValleyCSD.com

PARENT REQUEST FOR THE ADMINISTRATION OF PRESCRIPTION MEDICATION

STUDENTS NAME_____**DATE**_____**GRADE**_____
MEDICATION_____**DOSAGE**_____**TIME**_____
DATE TO BEGIN_____**DATE TO END**_____
REASON FOR MEDICATION_____
ANY SPECIAL INSTRUCTIONS_____

*The medication **MUST** be in the **ORIGINAL CONTAINER** as dispensed.
*The medication label must have the student's name, name of medication, directions for use and date dispensed.

I request the above student to be given the medication at school according to the prescription instructions. The student has experienced **no** previous side effects from the medication. I further agree that school personnel may contact the prescriber as needed and the medication information may be shared with school personnel who need to know.

I understand the law provides that there shall be no liability for civil damages as a result of the administration of medication where the person administering the medication acts as an ordinary reasonably prudent person would under the same similar circumstances.

I agree to provide safe delivery of medication to and from school and pick up remaining medication.

PARENT/GUARDIAN SIGNATURE_____
DATE_____**PHONE NUMBER**_____
ALTERNATE PHONE NUMBER_____