MEDICATION PERMISSION REQUEST FORM

U.S.D. 480 requires the following for all students who need to take medication during school hours:

1. A physician's written order for medication needed (complete **A** below)
2. Parent/guardian written request for medication to be administered (complete **B** below)
3. Bring the medication in the original prescription bottle/container to the office, properly labeled by a registered pharmacist as prescribed by law
4. The student must take the initial dose of medication at home.
5. Parent/guardian and physician signatures for self administration of medicine for the treatment of anaphylactic reactions or asthma (complete **C** on reverse, in addition to **A** and **B**).

Name of Student_____ School_____

Date of Birth_____ Grade_____

A TO BE COMPLETED BY PHYSICIAN

(must be an M.D., D.O., or A.R.N.P.)

Name of medication_____

Reason for administration_____

Specific time(s) _____**Specific** dose(s)_____

Length of time needed_____

Are there any restrictions? Yes_____ No_____ If yes, what and how long? _____

_____

_____ _____

Printed name of physician Signature of physician

_____

Date

B TO BE COMPLETED BY PARENT/GUARDIAN

I request that my child receive the above medication as directed at school and release the school district and school personnel from any liability. My signature on this form allows this information to be discussed with physician, pharmacist, teachers and staff as needed.

_____ _____

Parent/guardian signature Date

_____

Telephone number

9/05

c

TO BE COMPLETED BY PHYSICIAN

The undersigned health care provider does certify that the undersigned is the health care provider for this student. The student has been instructed on the self administration of the previously described medication. The undersigned is further of the opinion that the student should be authorized to undertake said self medication while in school.

_____ _____

Printed Name of Physician Signature of Physician

_____

Date

TO BE COMPLETED BY PARENT/GUARDIAN

I, _____, the parent/guardian of the above-named student, request the student to self administer the medication described above. I further certify to USD 480 that the student has been instructed on self administration of the medication and is authorized to do so while in school.

I acknowledge USD 480 and its employees and agents incur no liability for any injury resulting from the self administration of the above medication and further agree to indemnify and hold USD 480 and its employees and agents harmless against any claims, demands, damages, liabilities, or causes of action relating to the student's self administration of the above medication and do hereby release USD 480, its employees and agents from any such liability, claims, demands, damages or causes of action.

_____ _____

Printed Name of Parent/Guardian Signature of Parent/Guardian

_____

Date