USD #415

REQUESTING AUTHORIZED STAFF TO ADMINISTER PRESCRIPTION MEDICATION

Name of Student _____ DOB _____

School _____ Grade _____

Teacher(s) _____

Medication _____ Dosage _____

Date Medication to start at school _____ Diagnosis/Reason for RX _____

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 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.

Updated 2022