EASTON VALLEY SCHOOL DISTRICT

Home of the Easton Valley RIVERHAWKS

PARENT REQUEST FOR THE ADMINISTRATION OF OVER THE COUNTER MEDICATION

STUDENT'S NAME_____DATE_____GRADE_____

MEDICATION_____DOSAGE_____TIME_____

DATE TO BEGIN_____DATE TO END_____

REASON FOR
MEDICATION_____

ANY SPECIAL INSTRUCTIONS_____

MEDICATION MUST BE THE ORIGINAL LABELED CONTAINER.

The student has experienced **no** previous side effects from the above medication.

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 ordinarily 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_____