

**REQUEST FOR MEDICATIONS TO BE ADMINISTERED IN SCHOOL**

Name of Pupil: \_\_\_\_\_ Grade: \_\_\_\_\_ DOB \_\_\_\_\_

Address: \_\_\_\_\_

Parent(s)/Guardian: \_\_\_\_\_

Emergency Telephone Number (s) \_\_\_\_\_

Medication: \_\_\_\_\_

Dosage \_\_\_\_\_

Time/Circumstances of Administration: \_\_\_\_\_

Duration: \_\_\_\_\_

Restrictions: Physical Education      Yes                      No Restrictions

If yes, how long \_\_\_\_\_

Other \_\_\_\_\_

Physician's Name (Please Print) \_\_\_\_\_

Address: \_\_\_\_\_

Telephone Number: \_\_\_\_\_

Physician's Signature: \_\_\_\_\_ Date: \_\_\_\_\_

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**PUPIL SELF ADMINISTRATION OF MEDICATION (PHYSICIAN'S CERTIFICATION)**

I certify that the above named pupil is capable of and has been instructed in the proper use/ method of administration and must be in possession of medication (as described above) at all times.

PHYSICIAN'S SIGNATURE \_\_\_\_\_ DATE \_\_\_\_\_

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**Parent/ Guardian Consent**

The school nurse at \_\_\_\_\_ School has permission to administer the above medication to my child as prescribed by physician. We/I give permission to the school nurse to contact the physician if necessary. We/I also acknowledge that the district or its employees shall incur no liability as a result of the administration of medication by of the above medication or injury arising from the self administration of medication by the pupil and indemnify and hold harmless the district and its employees or agents against any claims arising out of the self –administration of medication by my child.

Parent/Guardian Signature: \_\_\_\_\_ Date: \_\_\_\_\_