File: JHCD-E

REQUEST TO ADMINISTER PRESCRIBED MEDICATIONS TO A STUDENT DURING SCHOOL HOURS

Student Name ______________________________ Date of Birth ____________________

Address ______________________________ Teacher ________________ Grade __________

This will serve as an official request for designated school personnel to administer prescribed medication to my child during school hours as indicated below.

I understand and agree that the principal, his/her agent, has no responsibility for the content of said medication, nor for the refilling of said prescription, nor for the safeguarding of said prescription, other than precautions normally taken with respect to school property.

______________________________ ____________________

Parent / Guardian Signature Date

______________________________ ____________________

Printed Name of Parent / Guardian Daytime phone number

ALL MEDICATION MUST BE IN THE ORIGINAL PHARMACY DISPENSED CONTAINERS.
LABEL MUST MATCH INSTRUCTIONS FROM DOCTOR ON THIS FORM.

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PHYSICIAN STATEMENT

To the Physician:

The Liberty Union-Thurston Board of Education urges you to schedule the taking of medications by students at times outside of school hours. When that is not possible, the receiving or using of medications will be permitted, insofar as feasible, during school hours. Medication in pill form is preferable to liquids for use in school.

I verify that this medication must be taken by ______________________________
Name of Student

____________________ ____________________ ____________________
Medication Dosage Route

Diagnosis for which medication is prescribed: ______________________________

Medication is to be taken at the following times: ______________________________

Instructions or precautions (including possible side effects): ______________________________

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Adverse reactions that need to be reported to the physician: ______________________________

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Prescription beginning date: ______________ Prescription expiration date: ______________

Date form completed: ______________ Physician Signature ______________

Physician Printed Name: ______________________ Phone #: ______________

Physician Address: ______________________________

A new form must be completed for each dosage/medication/doctor change.
Each school year a new form must be completed for each medication.

[Adoption date: January 10, 2000]
[Revised: April 9, 2007]
[Revised: July 14, 2008]