POLICY #4281

ADMINISTERING MEDICATION TO STUDENTS

PARENTS:

THIS FORM MUST BE COMPLETED. DO NOT SEND MEDICATION TO SCHOOL UNLESS THE FORM BELOW HAS BEEN COMPLETED AND RETURNED TO SCHOOL WITH THE MEDICATION.

SECTION I.

PHYSICIAN'S PERMISSION

Student's Name ____

Address ____

is under my care for ____.
(Diagnosis)

He/She will start ______________________ on ______________________,
(Medication) (Date)

and it is to be administered ____.
(Time, Interval & Dosage)

The medication will be continuous until ______________________________.
(Date)

Severe adverse reactions to observe: ______________________________

____

Special instructions for administering, storing, or sterile conditions:

____

Report adverse reactions to: ____,
(Physician Name)

____,
(Physician Address)

______________________________.
(Physician Emergency Phone)

____
(Physician Signature) (Date)

SECTION II.

PARENTAL PERMISSION

The school has my permission to administer the prescribed medication to

______________________________, according to the physician's instructions.
(Student Name)

____
(Parent Signature) (Date) (Emergency Phone)