CHIPPEWA VALLEY SCHOOLS

Request for Administration of Prescription Medication to Student

Student Name:_____ **Date of Birth**: _____ **Grade**: _____

School: _____ **Date**: _____

Under certain conditions, as a service to you and for the welfare of your child, school personnel may agree to honor parent and doctor requests for the administration of prescribed medication to students for limited periods of time. All medications must be in the original container, clearly labeled, and kept locked in the school office at all times.

To be completed by Physician:

I recommend that the prescribed medication be given to:_____

Name of Medication:_____ Dosage: _____

Reason for Medication (optional): _____ Frequency: _____

Start Medication: _____ Stop Medication: _____
(Date) (Date)

____Tablet/Capsule ____ Liquid ____ Inhaler ____ Injection ____ Nebulizer ____ Other

Special Instructions: _____

_____ _____

Physician's Name (please print) **Physician's Signature**

Physician's Telephone Number: _____ **Date:** _____

To be completed by Parent or Legal Guardian:

I do hereby request and authorize administration of medication to be given to the above named student.

- I will assume responsibility for safe delivery of the medication to school.
- I will notify the school immediately if there is any change in the use of the medication or the prescribed treatment.
- I release and agree to hold the Board of Education, its officials, and its employees harmless from any and all liability, foreseeable or unforeseeable, for damages or injury resulting directly or indirectly from this authorization.

_____

Signature of Parent/Legal Guardian

Telephone Numbers: **Daytime:**_____ **Home:** _____ **Cell:**_____