REAVIS HIGH SCHOOL 2016-2017
REQUEST FOR THE ADMINISTRATION OF MEDICINE

MEDICATIONS CANNOT BE ADMINISTERED AT SCHOOL WITHOUT A DOCTOR'S WRITTEN ORDER AND A WRITTEN REQUEST FROM THE PARENT OR GUARDIAN.

_____ _____

Student's Name **Student's I.D. #**

Physician Section

Name of medication:_____ Dosage:_____ Route:_____ Time: _____

Expected discontinuation date: _____Condition and purpose for prescribed medication: _____

_____List possible side effects: _____

Medication(s) must be administered during school hours for this student to attend school. _____(no) ___(yes) Is student receiving any other medication? _____(no) _____(yes) If yes, name and list possible side effects: _____

Physician, *please complete this section if the student has been prescribed asthma medication, EpiPen, or if medication* is *taken after normal school hours.*

I certify that _____ has been instructed in the use and self-administration of
Name of Student

_____ _____He/she understands the need for the medication and the necessity
Name of Medication

to report to school personnel any unusual side effects. He/she is capable of using this medication independently.

_____ _____ _____

Printed Name of Physician Signature of Physician Date

_____ _____ _____

Address Phone Number Emergency Number

PARENT SECTION

All medication to be taken at school must be brought to the nurse's office. It must be in the original labeled container as dispensed by the pharmacy or physician. The label must contain the student's name, name of medication, date, dosage, and directions in which the medication is to be taken. I hereby request and grant permission for District #220 school personnel to dispense medication to my

Son/Daughter _____according to _____
Name of Student Physician's Name

and above instructions. I further waive any claims against the school district, its employees and agents arising out of the administration of said medication. I agree to hold harmless and indemnify the school district, its employees and agents, either jointly or severally, from and against any and all liability, claims, demands, damages or causes of action or injuries, costs and expenses, including attorneys' fees, resulting from or arising out of the administration of medication. I further authorize the release and exchange of information between Reavis High School and the physician regarding above listed medications. I agree with the above information that was completed by our physician.

_____ _____ _____

Parent Signature **Home Phone Number** **Date**

**** All medication not picked up by the last day of school will be disposed.***