

REAVIS HIGH SCHOOL 2017-2018
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.**