



**SOUTHMONT SCHOOLS  
HEALTH SERVICES**

**MEDICATION REQUIRED DURING SCHOOL HOURS**

**ALL MEDICATIONS MUST BE IN THE ORIGINAL CONTAINER LABELED  
WITH THE STUDENT'S NAME.**

Student's Name \_\_\_\_\_

Name of Medication \_\_\_\_\_

Dosage \_\_\_\_\_

Time/Times to be given \_\_\_\_\_

Termination date for administrating medication \_\_\_\_\_

Special Instructions \_\_\_\_\_

Physician \_\_\_\_\_ Phone \_\_\_\_\_

It is necessary for the above medication to be taken during the school day. Therefore, I request that school staff members administer medication to my child during the school day in accordance with the above written instructions. I am sending the medication in its original container with my child's name on it.

I will assume responsibility for delivery of the medication to school. I will hand deliver medications that are controlled substances (Ritalin, Adderall, pain medications, etc.) I will notify the school if there is any change in the dose of medication.

I release and agree to hold the school district, school board, its officials and employees harmless from any and all liability for damages or injury resulting directly or indirectly from this authorization.

I give the school nurse permission to consult with the prescribing/attending physician regarding benefits and side effects of this medication.

\_\_\_\_\_  
Signature of Parent \_\_\_\_\_ Date

\_\_\_\_\_  
Home phone \_\_\_\_\_ Work/Cell phone