Old Trail School

Prescriber and Parent request for administration of medication at school.

Place Student Picture here

Student:_____DOB_____Grade:_____

Address_____City/Zip_____

Name of Medication and Dosage_____

(One Medication per Form)

Times of Day to be Administered_____

Number of Times/Intervals Medication is to be Administered_____

Adverse/Severe Reaction that should be reported to Physician_____

Special Instructions for Administration of Medication _____

_____

This medication can be safely administered by nonmedical personnel: Yes ❒ No ❒
It is impossible to arrange for this medication to be taken at home and, therefore, it must be administered during school hours. Yes ❒ No ❒

Date to Begin Medication **Date to End Medication**

This student is under my care. It is not possible to arrange for this medication to be taken at home under the supervision of a parent and therefore it must be taken during school hours.

_____ _____
Physician's Printed Name Phone number

_____ _____
Physician's Signature Date

TO BE COMPLETED BY PARENT/GUARDIAN:

Please regard my signature below as my assurance that I release Old Trail School, PSI, and any or all of the school's and PSI's officers or employees from any liability or damages resulting from the consequences or adverse reactions of our child's taking or failing to take this medication at the times prescribed. I also agree to keep the school informed in writing of any revision in the physician's prescription. I have had the opportunity to ask questions. They have been fully answered to my satisfaction.

_____ _____
Parent Name Phone number

_____ _____
Parent Signature Date

All medication forms expire at the end of the school year.