DEXTER COMMUNITY SCHOOLS

Parent's Request for Administration of Medication at School

Date:__________

Student Name:________________________________ DOB:______Grade:____ Teacher:________

☐ For prescription and over the counter medication given by school personnel

Top portion to be completed by health care provider; bottom portion to be completed by parent/guardian

Medication	Dose	Time	Route	Side Effects	Reason for taking

Start Date:_________ Stop Date:__________

List minimal frequency between doses (especially if p.r.n-as needed):______________________

If p.r.n, list symptoms/conditions under which medication is to be given:______________________

The Student is capable of **self-administering** the above medication (circle one) **YES** **NO**

The Student is capable of **self-possessing** the above medication (circle one) **YES** **NO**

Physician's Phone #: _______________ Fax#:________________

Address____

________________________________ __________ ____________________________

physician's signature date physician's printed name

To be completed by parent/guardian:

I request and give permission for my child (named above) to receive the above medication (prescription or over the counter-OTC) according to the prescribing health care provider's prescription OR direction for OTC AND school district policy. I also give permission for the health care provider('s)/ staff and school district staff to share information regarding my child's medication needs. I understand that the medication must be in the original pharmacy/over the counter medication container, labeled with student's name, **and if prescribed medication:** with name of prescribing health care provider, strength and dose of medication, and directions for use. 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 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.

I request and give permission for my child (named above) to self-administer (circle one): **YES** **NO,** self-possess (circle one): **YES** **NO,** the above medication (prescription or over the counter-OTC) according to the prescribing health care provider's prescription OR my direction (after consulting your physician for correct dosage) for OTC AND school district policy.

________________________________ __________ ____________________________ __________

parent/guardian signature date student signature date

For your child's safety with routine daily medication, he/she should receive at least the first dose of medication at home so you may observe him/her for signs and symptoms of adverse or allergic reactions.

☐ my child has received at least one dose of this medication at home

_initial

Rev. 10/2022