Attachment "A"

BURRELL SCHOOL DISTRICT

Private Physician Request For Administration of Prescription Medication

Dear Doctor:

The parent/guardian of _____
(Student's Name)
has requested that we administer medication(s), to the student during the school day. It is our procedure to request that medication be given before or after school hours whenever possible. If it is essential that the student receive the medication(s) during school hours, please complete the following information:

Medical diagnosis _____

Name of medication(s) _____

Dosage _____

Route of administration _____

Time schedule for administration _____

Duration of medication administration _____

Possible side effects or contraindications _____

_____

Curtailment of specific school activities (sports, shop, lab) _____

_____

Is student capable of self-administration? Yes _____ No _____

Date _____ _____
Physician's Signature

_____
Physician's Phone Number

_____
School Nurse

Attachment "B"

BURRELL SCHOOL DISTRICT

Parent Consent Form For Prescription Medication

To: _____
(Building Principal)

I (We) request that school personnel administer _____
(prescribed medication)

to _____according to the attached direction from
(Student's Name)

our attending physician.

As parent/guardian of _____, I (we) hereby release
(Student's Name)

the Burrell School District and all of its employees from any and all liability for damages our child may suffer as a result of this request. I understand that my child's school nurse will contact the physician for clarification of instructions as needed.

_____ _____
Date Parent/Guardian Signature