Fairfield Local Schools – School Health Service

Administration of Prescribed/Non-Prescribed Medication

PART I – To be completed by physician

Note: When possible, please schedule medication so it does not have to be administered during school hours.

Student Name:_____ Grade/Teacher:_____

Address:_____

Medication/Procedure:_____

_____

Side effects to be reported:_____

Special Instructions (duration/storage/etc.):_____

Physician's Name:_____ Phone:_____

Address:_____

Physician's Signature:_____ Date:_____

PART II – To be completed by parent/guardian

We/I understand that the administration of said medication is to be done under the supervision of a member of the adult school staff and/or trained clinic volunteers.

We/I understand that the school personnel are not legally obligated to administer medication to any child and, therefore, we (I) agree to hold the School District and its employees free from any and all responsibility for the results of such medication or the manner in which it is administered and to indemnity each of them against loss by reason of any civil judgment arising out of these arrangements which may be rendered against them.

We/I agree to deliver the medication to the school in the original container from the prescribing physician or licensed pharmacist, properly labeled by same, this label to include name of student, physician, date, dosage instructions (quantity/time), and name of medication. Non-prescribed medications must also be delivered in the original container.

We/I will notify the school immediately if we change physicians or medications or terminate the use of this medication for any reason, and will report immediately to the school to pick-up said medication.

Signature of Parent/Guardian:_____ Date:_____

Home Telephone:_____ Work Telephone:_____

PART III: To be completed by school

_____ Date:_____

Signature of Nurse (or person who will administer medication)