



MILLVILLE AREA SCHOOL DISTRICT
MILLVILLE, PENNSYLVANIA
REQUEST FORM TO ADMINISTER MEDICATION

(Student's Name) _____ must receive the following medication in order to maintain sufficient health to participate in the school program.

This section to be completed by physician OR copy of prescription attached.

Name of medication: _____

Diagnosis when needed: _____

Dosage to be administered: _____

Time to be administered: _____

Length of time medication is to be given: (cannot exceed current school year)

From: _____ To: _____

For inhaled medications (only):

- This student has been instructed in the proper way to use his/her medications. It is my professional opinion that he/she should be allowed to carry and use that medication by him/herself.
- It is my opinion that this student should not carry his/her inhaled medication by him/herself.
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Physician name: _____ Phone # _____

Signature of attending physician _____

THIS SECTION TO BE COMPLETED BY PARENT

I, therefore, request the School District personnel to give my child the above medication. I do hereby release, discharge, and hold harmless the School District and its agents and employees from any and all liability and claim whatsoever for the administration of the above medication to my child, should there develop a reaction from the medication, and/or ensuring that self-administered medication is taken.

Parent/Guardian Signature: _____