WILLIAMSBURG COMMUNITY SCHOOL DISTRICT

CONSENT FORM FOR PRESCRIPTION MEDICATION

TO: _____
Building Principal

I request the administration of this prescription medication to_____
according to the directions of our attending physician. *Student's Name*

As parent/guardian of _____, I hereby release the Williamsburg School District and all its employees from any and all liability for damages that our child may suffer as a result of this medication.

BOTTOM PART OF THIS FORM MUST BE COMPLETED BY PHYSICIAN

_____ _____
Date *Signature of Parent/ Guardian*

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Dear School Nurse:

It is essential that _____ receive the following medication

during school hours as prescribed herein.

Name of Medication _____

Dosage _____

Time to be Administered _____

Termination Date _____

Purpose of Medication_____

Possible Side Effects or Contradictions _____

Curtailment of specific activity _____
(sports, shop, lab, gym, etc.)

Other medication prescribed by physician that is taken outside of school hours _____

_____

Is the student capable of self-administration? _____

If this form is for asthma or emergency medication, is it necessary for the student to have possession of the

medication during school hours? _____

_____ _____
Print Physician's Name *Physician's Signature*

_____ _____
Date *Phone Number*