MOUNTAIN VIEW SCHOOL DISTRICT
11749 STATE ROUTE 106
KINGSLEY, PA 18826-9778
High School Office 570-434-2501
Fax Number 570-434-9582

PRIVATE PHYSICIAN REQUEST FOR ADMINISTRATION OF MEDICATION DURING SCHOOL HOURS

Dear Doctor: Grade____________

The parent/guardian of ______________________________has requested that we administer medication(s), namely____ 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.

Name of medication(s)____

Dosage____

How to be administered (oral or injection)______________________________

Time schedule for administration___________________________________

Duration of medication administration_________________________________

Possible side effects or contraindications________________________________

Curtailment of specific school activity (sports, shop, lab, etc.)_________________

Other medications prescribed by physician that student is taking outside of school hours____

Is student capable of self administration___________________________

____
Date

____
Physician Signature

____
Physician Phone Number

Thank you for your cooperation

____
School Nurse

TO BE COMPLETED BY PARENT/GUARDIAN

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, 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 medication.

Prescription Number______________________ Date on bottle______________________________

Date___________________________________ Signature of Parent/Guardian__________________