USD 385 – Andover Public Schools

Health Services

Medication Administration Release Form

I hereby certify that _____ has previously had at least one dose of the prescribed medication listed and did not have an adverse reaction. I request this medication(s) to be administered at school as prescribed by the physician. I understand that any school employee who administers this prescription to my child in accordance with written instructions from the physician or dentist (and USD #385 Board of Education Policy) shall not be liable for damages as a result of an adverse drug reaction suffered by the pupil, because of administering such a drug or because of a mislabeled or altered product. I hereby authorize USD #385 Department of Health Services personnel to exchange information regarding dispensing and monitoring of this medication with _____, the attending physician or dentist, or with the pharmacy as identified on the label of the prescribed medication container. All prescription medications must be PICKED UP from the Health Office by a parent or guardian on or before the last day of school.

_____ _____

Printed Name of Parent/Legal Guardian | Signature of Parent/Legal Guardian

_____ _____

Date | Telephone Number

NOTE: The as-labeled non expired medication must be brought to school in the original container appropriately labeled by the pharmacy, or physician, stating the name of the medication, the dosage and times to be administered.

Building: _____ Teacher/Grade_____/_____

Student's Name_____ Birth Date:_____

Medication:_____ Diagnosis:_____

Route:_____ Dosage:_____

Time to administer at school:_____ Special Instructions for Administration: _____.

_____

Requested Starting Date of treatment: _____ Duration (End Date):_____

_____ _____

Physician's Printed Name | Physician's Signature

_____ _____ _____

Date | Telephone Number | Fax Number