your responsibility to have your child's physician complete this form. This is a Health Department Regulation. If your child has a change in dose or time this form needs completed again. Medications will not be accepted unless this form accompanies it. Our Fax# 814-634-0832

MEYERSDALE AREA SCHOOL DISTRICT

ADMINISTERING MEDICATION TO STUDENTS

PARENT'S REQUEST

I/We hereby request that the Meyersdale Area School District, through its appropriate personnel, administer a physician's prescribed medication to my/our child as described below. I/We further hereby release and hold harmless, the Meyersdale Area School District and its employees , from any liability, injury or damages as a result of such administration of medicine.

Parent/Guardian Signature_____

Please Initial here is your child was prescribed an inhaler and you feel they are responsible to carry it with them and self medicate if necessary. _____

DOCTOR'S REQUEST

Consistent with the above request by the parents of the child identified below, I hereby request that the Meyersdale Area School District allow its appropriate personnel to administer a medication which I have prescribed as follows:

Child's Name_____

Diagnosis_____

Name of Medication_____

If an inhaler has been prescribed please see extra initial requirement for self medication below physician signature area.

Dosage_____

Time to be Administered_____

Possible Side Effects to watch for_____

_____

Termination Date_____

_____ _____

Date Physician's Signature

Please initial here if you have prescribed an inhaler and you feel this child can safely carry the medication on their person and self medicate when necessary. _____.