SKYLINE SCHOOLS, U. S. D. 438

School Year _____

Request for **Prescription Medication** to be administered during school attendance.

Name of Student _____Birthdate _____

School _____Grade _____

Name of Medication _____Purpose of Medication_____

Prescribed dosage_____Date Medication started _____

Time Medication is to be Given_____Expected duration of treatment_____

DATE_____ _____
Physicians Signature

_____
Phone Address

PARENT REQUEST to administer Medication at school.

I hereby request for the School Nurse, or Designee, to administer this medication as directed during the hours my child is in school in order to comply with the doctor's orders. I understand that it is my responsibility to furnish this medication. I further understand that any school employee who administers any drug or nonprescription medication pursuant to parental written request to my student in accordance with written instructions from the physician or dentist shall not be liable for damages as a result of an adverse medication reaction suffered by the student because of administering such medication. Date_____

_____
Signature of Parent or Guardian

_____
Phone Address

NOTE: Any Prescription Medication sent to school to be administered by the School Nurse or Designee MUST be accompanied by a signed parental consent form and a doctor's written order stating the student's name, dosage, how and when the medicine is to be given, and must have the doctor's signature to be valid. It must be in the original container with the pharmacist's label, stating the patient's and the doctor's name, dosage and instructions. Medication out of a bottle, box, etc. without this label cannot be given.

Revised April 2015