PARENTS REQUEST FOR GIVING MEDICINE AT SCHOOL

STERLING SCHOOL DISTRICT

Students Full Name _____ Date of Birth _____

Teacher _____ Grade_____

I request that school personnel see that my child receives the medication _____,

prescribed by _____for the period from _____ to _____.

Amount (dosage) _____Time: _____.

This medication is being given for: _____.

Inventory: _____ Expiration Date: _____

List any potential reactions with appropriate treatment:

_____

_____

I understand the medicine is to be furnished by me in the original container, currently dated, and labeled with the name of the medicine, the dosage to be given, time of day to be taken, and the expected duration of treatment. The physician's name must be on the label if it is a prescription medication. I further understand it is my responsibility to deliver and pick up medicines and to inform school of any changes.

_____

Name of Parent/ Guardian Work Phone Home Phone Cell Phone

_____ _____

Signature of Parent/ Guardian Date

_____ _____

*Signature of Physician Prescribing Medication Date

*Original prescription container could be accepted in lieu of signature.

I will not hold the school, Sterling School District, or school personnel liable for any adverse drug reaction when the medicine is administered according to prescribed methods._____

Parent: _____ Date: _____

Your Child and Medication at School

The Sterling School District is genuinely concerned with the health and welfare of your child. Because of this concern, the district has established rules and consistent procedures for the proper administration of prescribed medication during school hours. This consistency is needed due to the variety of health problems.