FRASER PUBLIC SCHOOLS

Request for Administration of **Prescription** Medication to Student

Name of Student: _____Date of birth: _____Grade:_____

School: _____Date:_____

Under certain conditions, as a service to you and for the welfare of your child, school personnel may agree to honor parent and doctor requests for the administration of prescribed medication to students for limited periods of time. All medications must be in the original container, clearly labeled, and kept locked in the school office at all times.

To be completed by Physician:

I recommend that the prescribed medication be given to:_____ _____

Name of Medication: _____Dosage:_____

Reason for medication (optional):_____Frequency: _____

Date start medication:_ _____ Date stop medication: _____

___Tablet Capsule___Liquid ___Inhaler___Injection___Nebulizer_Other (specify)_____

Instructions

_____ _____

Signature of Physician Date Printed name of Physician

Physician's Telephone Number:_____

To be completed by Parent or Legal Guardian:

I do hereby request and authorize administration of medication to be given to the above named student.

- I will assume responsibility for safe delivery of the medication to school.
- I will notify the school immediately if there is any change in the use of the medication or the prescribed treatment.
- I release and agree to hold the Board of Education, its officials, and it employees' harmless from any and all liability, foreseeable or unforeseeable, for damages or injury resulting directly or indirectly from this **authorization.**

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Signature of Parent or Legal Guardian Printed name of Parent or Legal Guardian

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