

JONES COUNTY PUBLIC SCHOOL

Request for Medication to be given During School Hours

To Be Completed by Physician

Name of Student _____ School _____

Medication _____ Dosage _____

(No injection will be given except in extreme emergency, such as allergy to wasp or bee sting.)

Time(s) medication is to be given : a.m. _____ p.m. _____ Route: _____

To be given from (date) _____ To (date) _____

Significant Information: (include side effects, toxic reactions, and omission reactions): _____

Contraindications for Administration _____

If an emergency situation occurs during the school day or if the student becomes ill, school officials are to:

a. Contact me at my office _____ Telephone Number _____

b. Take child immediately to the emergency room at _____

c. Other option _____

This medication will be furnished by parent or guardian within a container properly labeled by a pharmacist with identifying information, (e.g. name of child, medication dispensed, dosage prescribed, and the time it is to be given).

Date _____

Physician's Signature

DEA# _____

PARENT'S PERMISSION

I hereby give my permission for my child (name above) to receive medication during school hours. I understand that the school undertakes no responsibility for the administration of the medication. A licensed physician has prescribed this Medication. I hereby release the School Board and their agents and employees from any and all liability that may result from my child taking the prescribed Medication.

Signature of Parent or Guardian

Telephone _____ Date _____

(School Use Only)

Names and titles of persons to administer medication:

Approved by _____

Principal's Signature

Date