HERMANTOWN SCHOOLS
REQUEST TO ADMINISTER MEDICATIONS AT SCHOOL

Prescription medication must be supplied in a labeled pharmacy bottle. Over-the-counter medication must be supplied in the original, sealed container. Written authorization from the physician and parent must be provided before medications are given at school. The school nurse or health assistant may consult with the physician or licensed prescriber if questions occur regarding a medication and/or medication order. Copies of the complete medication policy are available from the school office.

Physician please complete:

STUDENT_____ BIRTH DATE_____

DIAGNOSIS_____

MEDICATION_____ DOSAGE_____

TIME TO BE GIVEN DURING SCHOOL_____

IF PRN, DESCRIBE INDICATIONS_____

ROUTE_____ START DATE_____ STOP DATE_____

SIDE EFFECTS OR RESTRICTIONS_____

Physician's signature_____ Date_____

Print or type physician's name_____ Phone_____

Parent please complete:

1. I request the medication listed above be given at school as prescribed by the physician/licensed prescriber.
2. I release school personnel from liability in the event any reaction results from the medication.
3. I give permission for the school nurse or health assistant to consult with the physician/licensed prescriber regarding the above medication or medical condition(s) being treated by the medication(s).

Parent/guardian signature_____ Date_____

My child takes the following medications at home:

Medication_____ Dosage_____ Time_____
Medication_____ Dosage_____ Time_____
Medication_____ Dosage_____ Time_____

01-24-01