Request for Administration of Medication

This form is for "long term" or emergency administration of medication, e.g. epilepsy, anaphylaxis, etc.

A. To Be Completed By Parent or Guardian

Student Name				DOB YYYYMMDD	
Parent / Guardian				Relationship	
Work Phone:		Home Phone		Cell Phone	
Work Phone:		Home Phone		Cell Phone	
Physician Name:				Phone	

B. To Be Completed By Prescribing Physician

Condition(s) which make medication necessary:

	Name of Medication	Dosage	Directions For Use / Storage Instructions
1.			
2.			
3.			
4.			
5.			

Additional Comments (possible reactions, consequences of missing medication, etc.)

Physician's Signature	Date

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C. To Be Competed By Parent or Guardian

I hereby request the school give medication as prescribed by the Physician on this form to my child. I will provide the school with regularly, updated medical information.

Name of Child	Parent / Guardian Signature	Date

As the school district is not engaged in the business of administration of medication, I also release School District No. 46 and its employees from any and all responsibilities for the loss of, failure to administer or adverse reaction to medication.

I recognize that:

A. It is not possible, despite best efforts, to provide a school environment that is guaranteed to provide no exposure to allergens;
B. Educators and support staff are not medically trained;
C. The primary responsibility for students' welfare remains with the parent/guardian and or student.

Parent/Guardian Signature	Date

D. To Be Completed By School Staff

Each school staff member who will be administering or supervising the medication must review the information on this form, indicate date and sign below.

Date	Signature	Comments, If any