PARENT/GUARDIAN'S REQUEST FOR GIVING MEDICATION OR TREATMENT AT SCHOOL

My student, _____, a student in _____
School requires medication and/or a medical procedure during the school day as prescribed by his/her physician. I hereby authorize the designated staff person to administer the medication/procedure prescribed below according to the directions. In consideration of the service, I (we) further hereby agree that I (we) will not hold liable, and will otherwise hold harmless, the Windham School District and any such member of the administration of the medication/procedure described below. This includes permission to confer with the physician, if necessary.
Date:_____Signature: _____

Print Name: _____

PHYSICIANS' STATEMENT

The above-named student _____requires medication and or a medical procedure during the school day as follows:
Diagnosis: _____
Medication:_____Dosage: _____
Time:_____Frequency/ Duration:_____
Route of Administration: _____

Possible side effects, adverse reactions, and contraindications:
_____
_____

Other medications the student is currently taking: _____

Identification of medical procedure (explanation and details, i.e., time and duration);
_____
_____
_____
_____

Date:_____Signed:_____
(Physician)
Physician Telephone #_____Print Name _____

All medication (over the counter and prescribed) must be in the original pharmacy labeled container and accompanied by this signed form. All medication to be administered by the school nurse shall be kept in a securely-locked cabinet which is kept locked except when opened to obtain medications. Emergency medications may be secured in other locations readily accessible only to those with authorization.