REQUEST FOR MEDICATION TO BE GIVEN DURING SCHOOL HOURS

Name of student _____ **School** _____ **Grade** _____

Medication Name and Dosage Amount _____
(No injection will be given except in extreme emergency, such as allergy to wasp or bee stings.)

Time(s) to be given: _____ **A.M. / ** _____ **P.M.**

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

Significant Information (include side effects, toxic reactions, 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 _____ **Tel. 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 give).

_____ **Date:**_____

Physician's Signature

DEA# _____

Parent's Permission

I hereby give my permission for my child (named above) to receive medication during school hours. I understand that the school takes no responsibility for the administration of the medication. This medication has been prescribed by a licensed physician. I hereby release the Lee County School Board and their agents and employees from any and all liability that may result from my child taking the prescribed medications.

_____ _____ _____

Signature of Parent/Guardian **Date** **Telephone Number**